

# CONFIDENTIAL PATIENT INFORMATION

Social Security No. \_\_\_\_\_

Drivers License # \_\_\_\_\_

Date \_\_\_\_\_

Name \_\_\_\_\_ Home Phone \_\_\_\_\_ Email \_\_\_\_\_

Address \_\_\_\_\_ Zip Code \_\_\_\_\_

Age \_\_\_\_\_ Birth Date \_\_\_\_\_ Marital Status: M S W D How many Children? \_\_\_\_\_

Occupation \_\_\_\_\_ Employer \_\_\_\_\_

Address \_\_\_\_\_ Office phone \_\_\_\_\_

Insurance Company \_\_\_\_\_ Agent Name \_\_\_\_\_ Policy # \_\_\_\_\_

Name of Spouse \_\_\_\_\_ Occupation \_\_\_\_\_

Employer \_\_\_\_\_ Office Phone \_\_\_\_\_

Patient's Nearest Relative \_\_\_\_\_

Address \_\_\_\_\_

Referred by \_\_\_\_\_

Date of Last Physical Examination \_\_\_\_\_

Have you ever suffered from:	YES	NO		YES	NO
1. Dizziness	<input type="checkbox"/>	<input type="checkbox"/>	8. Asthma	<input type="checkbox"/>	<input type="checkbox"/>
2. Backaches	<input type="checkbox"/>	<input type="checkbox"/>	9. Neuritis	<input type="checkbox"/>	<input type="checkbox"/>
3. Heart trouble	<input type="checkbox"/>	<input type="checkbox"/>	10. Digestive Disorders	<input type="checkbox"/>	<input type="checkbox"/>
4. Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	11. Nervousness	<input type="checkbox"/>	<input type="checkbox"/>
5. Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>	12. Sinus Trouble	<input type="checkbox"/>	<input type="checkbox"/>
6. Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	13. Anemia	<input type="checkbox"/>	<input type="checkbox"/>
7. Headaches	<input type="checkbox"/>	<input type="checkbox"/>	14. Cancer	<input type="checkbox"/>	<input type="checkbox"/>

Purpose of this Appointment \_\_\_\_\_

Other Doctors seen for this condition \_\_\_\_\_

Have you been treated for any health condition by a physician in the last year? [ ] Yes [ ] No

Describe \_\_\_\_\_

Remarks and additional information \_\_\_\_\_

## **PAYMENT IS EXPECTED AT THE TIME OF VISIT!**

Name of Person Responsible for Payment \_\_\_\_\_

Are you insured? [ ] YES [ ] NO Company \_\_\_\_\_

I understand and agree that health and accident insurance policies are an agreement between the insurance carrier and myself. Furthermore, I understand that the Chiropractic Associates of Lowe Chiropractic & Wellness will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to the Chiropractic Associates of Lowe Chiropractic & Wellness will be credited to my account upon receipt. However, I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered me will be immediately due and payable.

Patient's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Guardian or Spouse's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Information Taken By: \_\_\_\_\_ Date: \_\_\_\_\_