natural health chiropractic

Case # **PATIENT INFORMATION** Page 1 of

WELCOME! *Please allow us to make a copy of your photo ID and insurance cards.*

PLEASE PRINT

Full Name _____ Gender **M F** Home Phone_____

Address _____ City _____ St _____ Zip _____

Age _____ Birthdate _____ Marital Status: □ Single □ Married □ Wid. □ Div. □ Sep. # of Children _____

SS# _____ E-mail _____

Your Employer _____ Occupation _____

Employer Address _____

Work Phone _____ Cell Phone _____

Do you have health insurance? □ Yes □ No Plan/Group# _____

Spouse/Parent/Guardian Name _____ Relationship _____

Employer _____ Occupation_____

Work Phone _____

Who is your medical doctor? _____

Is your present condition related to a: □ Work Injury □ Automobile Accident □ Liability Case

How did you find out about our office?_____

Payment options today (please indicate): □ Cash □ Check □ MasterCard □ Visa □ Discover □ N/A

Health History

Please check any items that apply to you:

□ AIDS/HIV	□ Epilepsy	□ Infectious Disease	□ Osteoporosis	**Females**:
□ Allergy _____	□ Fractures	□ Kidney Disease	□ Pacemaker	□ Pregnant □ Nursing
□ Arthritis	□ Gout	□ Liver Disease	□ Parkinson's Disease	□ Take Birth Control Pills
□ Asthma	□ Heart Disease	□ Lung Disease	□ Polio	
□ Blood Disorders	□ Hernia	□ Migraines	□ Rheumatoid Arthritis	
□ Cancer	□ Herniated Disc	□ Multiple Sclerosis	□ Stroke	
□ Diabetes	□ High Cholesterol	□ Neurological Disease		

Reason for visit today_____

Have you had x-rays (MRI, etc.)? Where?: _____

Other health conditions or surgeries (with dates): _____

_____

Current medications: _____

_____

Daily Exercise:	□ None	□ Light	□ Moderate	□ Heavy
Physical demands of work:	□ Heavy	□ Moderate	□ Mild	□ Sedentary
Stress level of work:	□ High	□ Medium	□ Low	
Do you use:	□ Caffeine	□ Tobacco	□ Nicotine	□ Recreational Drugs □ Alcohol

Is there anything else we should know about you?_____

Authorization

I certify that I have read and understand the above information and answered all questions accurately to the best of my knowledge. I authorize this office to release any appropriate information during the course of my care including diagnosis and treatment records rendered to me (or my child) to third party payors and/or involved health practitioners. I authorize and request my insurance company to pay insurance benefits directly to this office for my care. I understand that if my insurance pays less than the actual bill for service, I agree to be personally responsible for payment of all services rendered on my behalf or my dependents. I understand that I am responsible for all co-payments and non-covered services. I agree that a photocopy of this agreement shall serve as the original.

X

_____

Patient's Signature (or parent if minor) Date