Patient Information Form

***Date Of 1st Visit*______/______/________ *Account # Issued*__________________ *X-Ray#*______________________**

First Name:__________________________ M.I.:_________ Last Name:_______________________ Phone: ( )______________________

Address____ City:_______________________________ State__________ Zip_________________

Age:_____________ Sex_____________ Birthdate:_____/____/_____ Marital Status (S M W D) Spouse's Name________________________

Social Security#_______-______-_______ Driver Licence#______________________ Occupation __________________________________

Employer __________________________________ Work ( ) ____________________ Work Address______________________________

E-Mail Address ____ Cell phone ____

How did you hear about our office:______________________________________ Person Responsible for this account:____________________________

Primary Insurance,*(Please give staff your card for verification)*

Insurance Company ____

Policy Holder:______________________________ Relationship to Patient:_______________________ S.S.#(of Policy Holder):_____________________________
Policy holder address(*If Different*):____ ID:_________________________Phone:_________________________________
Employer of Policy Holder:____ Date of Birth of Policy Holder:__________________________________

Secondary Insurance (If Applicable) *Insurance Company*____

Policy Holder:________________________________ Relationship to Patient:_______________________ S.S.#(of Policy Holder)________________________
Policy Holder Address(*if Different*):____________________________________ Group#:__________________________ Phone( ) ____________________
Employer of Policy Holder:____ Date of Birth of Policy Holder:_________________________

***What is your major complaint*:**____

Describe how pain started____

Date symptoms appeared ______/______/______ (if you dont know a specific date give an approximate date)

Is this condition due to an: ❍ Auto Accident ❍ Work Injury ❍ Other Accident (describe) ❍ Unknown Cause ❍ Illness(describe):____________
____

Have you had any symptoms before? (Y / N) If so, When? ____

Have you seen another doctor for this condition? ❍ M.D. ❍ Chiropractor ❍ Orthopedist ❍ Acupuncturist ❍ Other

Drs. Name:____ Date Consulted ______/______/______

Diagnosis / Dr's Comments:____

Treatment Received for this condition:____

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. I authorize payment from my insurance carrier directly to this office with the understanding that all monies will be credited to my account upon receipt. However, I clearly understand and agree that all services rendered to 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, and fees for professional services rendered me will be immediately due and payable. In the event of default, I promise to pay legal interest on the indebtedness together with such collection costs and reasonable attorney fees as may be required to effect collection.

Patients Signature:____ Date:___________________