

### Personal Information

Name: \_\_\_\_\_ Home Phone: \_\_\_\_\_

Work #: \_\_\_\_\_ Cell #: \_\_\_\_\_ E-Mail: \_\_\_\_\_

Address, City, State, Zip: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ Male / Female

Spouse's Name (Parent or Guardian) \_\_\_\_\_

# of Children: \_\_\_\_\_ Married Single Divorced Widowed

Occupation: \_\_\_\_\_ Employed By: \_\_\_\_\_

Social Security Number: \_\_\_\_\_

Work Address (City, State, Zip): \_\_\_\_\_

How were you referred to our office? \_\_\_\_\_

Have you had Chiropractic Care before? \_\_\_\_\_ When? \_\_\_\_\_

List other Doctors consulted for this condition:

1.) \_\_\_\_\_ Address: \_\_\_\_\_

2.) \_\_\_\_\_ Address: \_\_\_\_\_

Who is your Primary Care Doctor? \_\_\_\_\_

Where is your Primary Care Doctor located? \_\_\_\_\_ Phone #: \_\_\_\_\_

Is this injury work related? \_\_\_\_\_ Have you reported it to your employer? \_\_\_\_\_

Is this injury related to an automobile accident? \_\_\_\_\_

If yes, name YOUR auto insurance: \_\_\_\_\_ Policy #: \_\_\_\_\_

Claim # \_\_\_\_\_ Address: \_\_\_\_\_

Agent's Name: \_\_\_\_\_ Phone #: \_\_\_\_\_

Do you have any type of Health Insurance? \_\_\_\_\_ Company Name: \_\_\_\_\_

Address: \_\_\_\_\_ Policy #: \_\_\_\_\_

Are you covered under any other group or individual health policy through yourself or spouse?

If yes, Company Name: \_\_\_\_\_

Address: \_\_\_\_\_ Policy #: \_\_\_\_\_

Spouse's SSN: \_\_\_\_\_ Employer: \_\_\_\_\_

Address (City, State, Zip): \_\_\_\_\_

### Consent to treat a minor

I hereby give permission to evaluate and treat the patient shown above.

Signature of parent or guardian: \_\_\_\_\_ Date: \_\_\_\_\_

Notice: Not all patients require an x-ray evaluation to determine or verify a diagnosis nor type and length of care. If your examination warrants x-ray analysis, the following office policy prevails:

1. All first visit charges are payable when services are rendered.
2. The fee paid for x-ray is for analysis only. The film itself is the property of this office and cannot be released.

Method of payment you plan to use for today's visit charges: Cash Check Visa/Master Card

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