Patient Information

Today's Date: _____

Legal First Name: _____ **MI:** _____ **Last Name:** _____

Street: _____ **Apt:** _____

City: _____ **State:** _____ **Zip:** _____

Social Security #:_____ **Marital Status: S M W D Spouse:**_____

Language: _____English _____ Spanish _____ Indian _____ Japanese _____ Chinese _____ Korean _____ French _____ German _____ Russian _____ Other_____

Race: _____ White _____American Indian or Alaska Native _____ Asian _____Native Hawaiian/Other Pacific Islander _____ Black or African American _____ Hispanic or Latino _____ Decline to Answer _____Other_____

Ethnicity: _____ Hispanic or Latino _____Not Hispanic or Latino _____ Decline to Answer

Birthdate: _____ **Home Phone:** _____ **Work Phone:**_____

Age:_____ **Cell Phone:** _____ **Cell Carrier:** _____

Please check your contact preference: _____Home _____ Work _____ Cell _____Email _____ Postal Mail

Email home: _____ **Email wk:** _____

Emergency Contact:_____ **Phone Number:** _____

Whom may we thank for referring you to our office? _____

Occupation: _____ **Employer:** _____

Employer Address: _____

Insurance Information

We will make a copy of your insurance card/s and Legal ID. However, please complete the following information.

Are you the policy holder? Y N If no, who is policy holder: Spouse Parent Employer Other

Policy Holder's Name:
First Name: _____ **M.I.** _____ **Last Name:** _____

Policy Holder's Date of Birth: _____ **Policy Holder's SS#:** _____

Policy Holder's Employer: _____

Do you have secondary insurance coverage? Y N If yes, please complete the following:
Policy Holder's Name:
First Name: _____ **M.I.** _____ **Last Name:** _____

Policy Holder's Date of Birth: _____ **Policy Holder's SS#:** _____

Policy Holder's Employer: _____

Patient History

Why are you here (what are your main concerns/issues):

_____

_____

_____

_____

Past health history

Have you…	Yes	No	If yes, include date & provider seen
...been diagnosed with Diabetes?	□	□	_____
Type I____or Type II_____			
…been treated for hypertension?	□	□	_____

Do you smoke? □ Never □ Former Smoker □ Current/Every Day Smoker □ Current Some Day Smoker

Are you seeing anyone else for other problems or health conditions? □ Yes □ No

Medications

What medications are you currently taking? Include vitamins, herbs, minerals…

List Date Started, Brand Name, Generic Name, Strength, Dosage, Frequency, Duration, Quantity, Refills Available, Prescribed by…

Please be as specific as possible (and if needed continue on back).

_____

_____

_____

_____

Do you have allergies? □Food □Environmental □Medication □None

List Type of Allergy and Reaction

_____

_____

_____

Assignment & Release

Insurance Information

I understand and agree that health and accident insurance policies are an agreement between an insurance carrier and myself. Furthermore, I understand that this office 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 this doctors office 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, any fees or outstanding balances for services I have received will be immediately due and payable.

Patient's/Parent's/Guardian's Signature: _____

Consent of Professional Services and Release of Information

I herby authorize and release the doctor and whomever he/she may designate as his/her assistants, to administer treatment, physical examination, x-ray studies, laboratory procedures, chiropractic care or any clinic services that he/she deems necessary in my case; I furthermore authorize him/her to disclose all or any part of my patient record to any person or corporation which is or may be liable under a contract to this office or to the patient or to a family member or employer of the patient for all or part of the clinic's charge, including, and not limited to hospital or medical service companies, insurance companies, worker's compensation carriers, welfare funds, or the patient's employer.

Patient's/Parent's/Guardian's Signature: _____