PATIENT REGISTRATION & CONFIDENTIAL PERSONAL FILE

Please check the type of care desired so that we may be guided by your wishes when possible.

Relief Care ____ Corrective Care ____ Comprehensive Care ____

Check here ____ if you want the Doctor to select your care.

(PLEASE PRINT) Today's Date: ______________________

Patient's Name: ____

Address: ______________________________________ E-mail address: ________________________

City: ___________________________________ State: ____________________ Zip: ______________

Home Phone: (_______) ____________________ Work Phone: (_______) ________________________

Age: _______ Date of Birth: _________________ Sex (M / F) Marital Status: _____________________

If married, name of spouse: ____

If under 18, Guardian's name: ____

Social Security #: _________________________________ Medicare patients: Prefix ______Suffix ______

Occupation: _________________________ Place of Employment: ______________________________

Employer's Address: ____

Have you had prior chiropractic care? Yes _______ No _______ When? __________________________

Referred to our office by: ____

Your present complaints: ____

____

Have you ever had these symptoms before? Yes _______ No ________ When? ____________________

Is your compliant due to an accident? Yes _______ No ________ If yes, date: _______________________

Type of accident: Worker's Compensation: _______ Automobile: _______ Other: ____________________

Were you treated somewhere else before coming here? Yes _______ No ________

Where ? _________________________________ By Whom? ___________________________________

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FEES ARE PAYABLE AT THE TIME OF SERVICE, UNLESS OTHER ARRANGEMENTS ARE MADE IN ADVANCE

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Nearly all insurance policies provide chiropractic coverage, but benefits vary from company to company and from policy to policy. <u>Therefore, although we will fill out the insurance forms, the patient is personally responsible for payment of services. If it is necessary to send a statement, a service charge may be applied.</u>

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Do you have Chiropractic Insurance? Yes _____ No _____ Insurance Company: ______________________

*** Please submit insurance card for copying ***

Signature: ____