CONFIDENTIAL PATIENT INFORMATION

Date:_______________________

PERSONAL:

NAME____ (First and last name) SEX _____ (M or F) MARITAL STATUS ______ DATE OF BIRTH _________ (mo. day yr.) AGE ______ HOME PHONE________________ (Area code) Number

ADDRESS____ (Include street type, such as St., Ave., etc.) CITY___________________ STATE ______ ZIP CODE________

____

Social Sec. # | Occupation | Company Name | Location | Business Phone Number

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Spouse's First Name | Spouse's Soc. Sec. # | Spouse's Employer | Occupation

CELL # ________________________ E-MAIL _________________________________ CAN WE PUT YOU ON OUR MAILING LIST? ❑ YES ❑ NO

NAME OF NEAREST RELATIVE ____ PHONE _______________________________

WHO REFERRED YOU TO OUR OFFICE? ____

IS YOUR VISIT DUE TO AN ACCIDENT? ❑ NO ❑ YES (If yes, please see receptionist for Injury Report)

PRESENT COMPLAINT ____

BRIEFLY DESCRIBE SYMPTOMS ____

____

LIST OTHER DOCTOR(S) SEEN FOR THIS CONDITION ____

HAVE YOU EVER HAD SAME OR SIMUILAR CONDITION? ? ❑ NO ❑ YES (If yes, please describe) ____________________________________

____

DESCRIBE THE OPERATIONS YOU'VE HAD: ____ WHEN? __________________

HAVE YOU BEEN TREATED BY A PHYSICIAN FOR ANY HEALTH CONDITION IS THE LAST YEAR? ❑ NO ❑ YES

DESCRIBE CONDITION: ____

DATE OF LAST PHYSICAL EXAM ____

ARE YOU NOW TAKING ANY MEDICATION? ❑ NO ❑ YES WHAT KIND? ____

ARE YOU PREGNANT? ❑ NO ❑ YES DATE OF LAST MENSTRUAL PERIOD ____

INSURANCE DATA (Clinic policy requires payment arrangements to be made on the first visit)

DO YOU HAVE INSURANCE? ❑ NO ❑ YES INS. COMPANY NAME ____

I.D. NO. ____ POLICY GROUP NO. ____

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. I permit this office to endorse co-insurance remittances for the conveyance of credit to my account, 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 understand that if I suspend or terminate my care and treatment, any fees for professional services rendered to me will be immediately due and payable, unless prior arrangement are made. I hereby authorize the doctors at First Choice Chiropractic Centres and whomever they may designate to administer treatment as they so deem necessary. I agree to pay 1% (12% annual) interest on unpaid balances greater than 90 days old. I certify that the above information is true and correct.

PATIENT'S SIGNATURE ____

PARENT'S OR GUARDIAN'S SIGNATURE ____

Medicare Lifetime Authorization

I request that payment of authorized Medicare benefits be made on my behalf to the First Choice Chiropractic Centres for any services furnished to me by their physicians. I authorize the release of medical information about me to the CMS (Center for Medicare and Medicaid Services) and its agents any information needed to determine the benefits payable for services provided.

PATIENT'S SIGNATURE ____

If any of the following are relevant to your health history, please circle **Y**. If yes, please circle **now** if it is a current or recent problem or **ever** if it is a past problem and not currently bothering you.

For office use only

Y/N	HEADACHES	(now, ever)	Onset______	Freq.______	Dur.______	Int.______
Y/N	DIZZINESS	(now, ever)	Onset______	Freq.______	Dur.______	Int.______
Y/N	FATIGUE	(now, ever)	Onset______	Freq.______	Dur.______	Int.______
Y/N	WEIGHT LOSS	(now, ever)	Onset______	Freq.______	Dur.______	Int.______
Y/N	NIGHT PAIN	(now, ever)	Onset______	Freq.______	Dur.______	Int.______
Y/N	FAINTING	(now, ever)	Onset______	Freq.______	Dur.______	Int.______
Y/N	VISION	(now, ever)	Onset______	Freq.______	Dur.______	Int.______
Y/N	ALLERGIES	(now, ever)	Onset______	Freq.______	Dur.______	Int.______
Y/N	SINUS	(now, ever)	Onset______	Freq.______	Dur.______	Int.______
Y/N	HEART	(now, ever)	Onset______	Freq.______	Dur.______	Int.______
Y/N	CHEST PAIN	(now, ever)	Onset______	Freq.______	Dur.______	Int.______
Y/N	PALPITATIONS	(now, ever)	Onset______	Freq.______	Dur.______	Int.______
Y/N	BLOOD PRESSURE	(now, ever)	Onset______	Freq.______	Dur.______	Int.______
Y/N	DIABETES	(now, ever)	Onset______	Freq.______	Dur.______	Int.______
Y/N	LUNGS	(now, ever)	Onset______	Freq.______	Dur.______	Int.______
Y/N	STOMACH	(now, ever)	Onset______	Freq.______	Dur.______	Int.______
Y/N	KIDNEY	(now, ever)	Onset______	Freq.______	Dur.______	Int.______
Y/N	LIVER	(now, ever)	Onset______	Freq.______	Dur.______	Int.______
Y/N	MENSTRUAL	(now, ever)	Onset______	Freq.______	Dur.______	Int.______
Y/N	URINARY	(now, ever)	Onset______	Freq.______	Dur.______	Int.______
Y/N	CONSTIPATION	(now, ever)	Onset______	Freq.______	Dur.______	Int.______
Y/N	DIARRHEA	(now, ever)	Onset______	Freq.______	Dur.______	Int.______
Y/N	LEG PAIN	(now, ever)	Onset______	Freq.______	Dur.______	Int.______
Y/N	ARM PAIN	(now, ever)	Onset______	Freq.______	Dur.______	Int.______
Y/N	NUMBNESS	(now, ever)	Onset______	Freq.______	Dur.______	Int.______
Y/N	NECK PAIN	(now, ever)	Onset______	Freq.______	Dur.______	Int.______
Y/N	MID-BACK PAIN	(now, ever)	Onset______	Freq.______	Dur.______	Int.______
Y/N	LOW BACK PAIN	(now, ever)	Onset______	Freq.______	Dur.______	Int.______
Y/N	SHOULDER PAIN	(now, ever)	Onset______	Freq.______	Dur.______	Int.______
Y/N	HIP PAIN	(now, ever)	Onset______	Freq.______	Dur.______	Int.______

Y/N SURGERY ______________________________

Y/N FRACTURES ______________________________

Y/N CAR ACCIDENT ______________________________

Y/N WORK INJURY ______________________________

Y/N OTHER HISTORY ______________________________

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