

# Welcome

## ABOUT YOU

Today's Date: \_\_\_\_\_ File #: \_\_\_\_\_

Name: \_\_\_\_\_

What you Prefer To Be Called: \_\_\_\_\_  Male  Female

Birth date: \_\_\_\_/\_\_\_\_/\_\_\_\_ Age: \_\_\_\_\_ SS#: \_\_\_\_\_

Home Address: \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone#: \_\_\_\_\_

Other Phone#: \_\_\_\_\_

Referred By: \_\_\_\_\_

Employer: \_\_\_\_\_ How Long? \_\_\_\_\_

Employer's Address: \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Occupation: \_\_\_\_\_ Work Phone #: \_\_\_\_\_

Marital Status:  Single  Married  Divorced  Separated  Widowed

Spouse's Name: \_\_\_\_\_

## INSURANCE INFO

Company Name: \_\_\_\_\_

Address: \_\_\_\_\_

Phone #: \_\_\_\_\_

Insured's SS# : \_\_\_\_\_

Group # (Plan, Local or Policy #): \_\_\_\_\_

Primary care Physician: \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Insured's Name: \_\_\_\_\_

Relation: \_\_\_\_\_ Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_

Insured's Employer: \_\_\_\_\_  
Please inform front desk of 2nd Insurance source.

## IN EVENT OF EMERGENCY

Who should we contact? \_\_\_\_\_

Relation: \_\_\_\_\_

Home Phone #: \_\_\_\_\_

Work Phone #: \_\_\_\_\_

## REASON FOR VISIT

Have you ever been treated by a chiropractor before?  Yes  No

If so, please explain: \_\_\_\_\_

The reason for this visit is a result of (*Please Circle*): work, sports, auto, trauma or chronic

(*Explain what happened*): \_\_\_\_\_

Please describe the pain & it's location: \_\_\_\_\_

When did condition begin? \_\_\_\_\_

Is this condition getting worse?  Yes  No  Constant  Comes and goes

Is this condition interfering with you (*Please Circle*): work, sleep, or daily routine

If so, please explain: \_\_\_\_\_

Have you had this or similar conditions in the past?  Yes  No

If so, please explain: \_\_\_\_\_

Have you been treated by a Medical Physician for this condition?  Yes  No

If so, where? \_\_\_\_\_

- We invite you to discuss with us any questions regarding our services. The best health services are base on a friendly, mutual understanding between provider and patient.
- Our policy requires payment in full for all services rendered at the time visit, unless other arrangements have been made with the business manager. If account is not paid within 90 days of the date of service and no financial arrangements have been made, you will be responsible for any expenses incurred in collecting your account.
- I authorize the staff to perform any necessary services needed during diagnosis and treatment. I also authorize the provider to release any information required to process insurance claims.
- I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes in my medical status.

Signature \_\_\_\_\_ Date \_\_\_\_\_