Back To Action Chiropractic Center

Confidential Patient Information

Date _____ Name _____
First, Middle Initial & Last Name

Sex _____ Marital Status _____ D.O.B. ___/___/___ Age _____ Home Phone _____
M or F Month Date Year Area Code/Number

Address _____ City _____ State _____ Zip Code _____
Include Street type such as St., Ave., etc.

Social Sec # _____ Occupation _____ Company Name _____ Location _____ Work Phone Number _____

Guardian/Spouse's Full Name _____ Guardian/Spouse's D.O.B. _____ Guardian/Spouse's Social Sec # _____ Guardian/Spouse's Employer _____ Location _____ Work Phone Number _____

E-mail Address _____

Name of nearest relative (not your spouse):_____ Phone _____

Who referred you to our office? _____

Is your visit due to an accident? ☐ No ☐Yes (if yes, please see receptionist for an injury report.)

BRIEFLY DESCRIBE YOUR HEALTH GOALS _____

List other doctor(s) seen for this condition _____

Medical history (if any of the following are relevant to your medical history, please check accompanying box:)

☐ Cancer	☐ Muscular Dystrophy	☐ Rheumatic Fever	☐ Digestive Disorders
☐ Polio	☐ Multiple Sclerosis	☐ Scarlet Fever	☐ Sinus Trouble
☐ Tuberculosis	☐ Convulsions	☐ Nervousness	☐ Backaches
☐ High Blood Pressure	☐ Epilepsy	☐ Asthma	☐ Numbness
☐ Heart Trouble	☐ Concussion	☐ Dizziness	☐ Arthritis
☐ Diabetes	☐ Hepatitis	☐ German Measles	☐ Venereal Disease

Describe any operations you've had and the dates: _____

Name of Primary Doctor:_____ Clinic Name:_____

Have you been treated by a physician for any health condition in the last year? ☐ Yes ☐ No

Describe Condition_____ Date of last physical exam_____

Are you now taking any medication? ☐Yes ☐No. What kind?_____

Are you allergic to any medication? ☐Yes ☐No. What kind? _____

Are you pregnant? ☐Yes ☐No. Date of last menstrual period:_____

Do you have insurance? ☐ Yes ☐ No Company _____

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. 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 office will be credited to my account upon receipt. I permit this office to endorse co-issued 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. It is my understanding that my credit may be checked if Back To Action Chiropractic Center extends credit to me and I also 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 arrangements are made. I hereby authorize the doctor at Back To Action Chiropractic Center and whomever he may designate as his assistant to administer treatment as he so deems necessary and also authorize the release of any information acquired in the course of my examination or treatment. I certify that the above information is true and correct.

Patient's (or Parent/Guardian's) Signature _____