

COLLARD CHIROPRACTIC & ACUPUNCTURE

PATIENT PERSONAL/ CONFIDENTIAL DATA

Patient: _____ Date: _____
Social Security No.: _____ - _____ - _____ Date of Birth: _____ Age: _____ Sex: M F
Home Address: _____ City: _____ State: _____ Zip: _____
Home Phone: _____ Cell Phone: _____ Is it ok to text this phone? Y N
E-mail address _____ Marital Status: _____
Employer: _____ Address: _____
Name of Spouse _____ No. of Children: _____
Spouses Employer: _____ Address: _____

How did you learn of this clinic? _____
If referred who referred you? _____

Do you have insurance? Y N
Name of Insurance: _____

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 Chiropractic 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 the Chiropractic 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 for professional services rendered to me will be immediately due and payable.

Signature Patient: _____ Signature Physician: _____
Date: _____ Date: _____

DESCRIBE YOUR CURRENT PROBLEM AND HOW IT BEGAN:

- Headache Neck pain Mid-back pain Low back pain Extremity pain
 Other: _____
Is this? Work Related Auto Related N/A

Date Problem Began: _____
How Problem Began: _____
What makes the conditions better? _____
What makes the conditions worse? _____
Other Doctor seen for this condition: _____

How often are your symptoms present? 0-25% 26-50% 51-75% 76-100%

