CONFIDENTIAL PATIENT INFORMATION

Social Security Number ____ Today's Date __________________

Name ____ Telephone # (home) ___________________________

Mailing Address ______________________________________ Telephone # (cell) _____________________________

City ______________________________ State ______ ZIP __________ - ________ Marital Status: S M D W

Birth Date _________________________ Age _______ Gender: F M Number of children _________

Employer _______________________________________ Occupation ____

If married, spouse's name ____________________________________ Spouse's Birth Date ________________________

Name of nearest relative NOT living with you ________________________________ Telephone # _____________________

Mailing Address ___________________________________ City ____________________ State ______ ZIP __________

Referred to our office by ___________________________________ Date of last medical or chiropractic exam ___________

Do you suffer from:	YES	NO		YES	NO		YES	NO
Dizziness	_____	_____	Asthma	_____	_____	Anemia	_____	_____
Headaches	_____	_____	Arthritis	_____	_____	Nervousness	_____	_____
Sinus problems	_____	_____	Cancer	_____	_____	Tuberculosis	_____	_____
Backaches	_____	_____	Diabetes	_____	_____	Digestive disorders	_____	_____
Nerve pain / numbness	_____	_____	Heart Trouble / Pacemaker	_____	_____			

Purpose of this appointment ____

____

Other health care providers seen for this condition ____

Has a physician treated you for any health condition in the last year? YES ______ NO ______ Whom? _______________________

Describe ____

Remarks and any additional information ____

PAYMENT IS EXPECTED AT THE TIME OF VISIT

Name of person responsible for payment ____

Name of Health Insurance Company ____

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and the insured. I understand that Total Health Chiropractic will prepare necessary reports and forms to assist in collection from the insurance company and that any amount authorized to be paid directly to Total Health Chiropractic will be credited to my account upon receipt. However, I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment.

Patient's Signature ____ Date _____________

Guardian's signature if under 18 ____________________________________ Date _____________