WELCOME!

Date_____

CONFIDENTIAL PATIENT INFORMATION

Name:_____

Address: _____City: _____ Zip: _____Home Phone: (____)_____

Age: _____ Sex: M θ F θ Birthdate: _____ Marital Status: S θ M θ W θ D θ Number of Children: _____

Occupation: _____ Business Name: _____

Business Address: _____ Office Phone: (____)_____

Spouses Name: _____ Referred By: _____

Person, with address, to contact in an emergency: _____

Address: _____ Phone: _____

Date of last physical exam: _____ With whom? _____ Where? _____

Reported findings: _____

Has your back or neck been x-rayed less than 3 years ago? _____ Where? _____

List all surgery, serious illnesses, hospitalization (with year in brackets): _____

_____

_____

_____

List all past dislocations, broken bones, and major dental work (with year in brackets): _____

_____

Have you ever suffered from:

θ Dizziness	θ Arthritis	θ Nervousness
θ Backaches	θ Headaches	θ Sinus Trouble
θ Heart Trouble	θ Numbness	θ Anemia
θ Diabetes	θ Asthma	θ Rheumatic Fever
θ Breathing Problems	θ Neuritis	θ Cancer
θ Tuberculosis	θ Digestive Disorders	θ Venereal Disease

Purpose of this appointment: _____

_____

Other doctors seen for this condition: _____

What medications / drugs are you taking (state reason in brackets following drug): _____

_____

Remarks and additional information: _____

PAYMENT IS EXPECTED AT TIME OF VISIT

Name of person responsible for payment: _____

Address (if different than yours): _____

PATIENT AGREEMENT:

I understand and agree that health and accident insurance policies are an arrangement between my insurance carrier and myself. Furthermore, I understand that Natural Arts Chiropractic will assist my insurance company in the filing of my claim which I submit and that any amount inadvertently paid directly to the Chiropractic Clinic will be returned to my insurance carrier and that I am personally responsible for payment, both for services when rendered and for missed appointments if I fail to give twenty-four hour advance notice of cancellation. Natural Arts Chiropractic is not a Medicare provider.

Patients Signature _____ SS# _____ Date _____

Guardian or Spouses Signature Authorizing Care_____

Natural Arts Chiropractic

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