PERSONAL HISTORY

Name: ____Date: ______/______/__________

Address: ____ Apt. #: ____________

City: ____ State: _____________ Zip: __________________

Cell#: (______) ________ - _________ Home#: (______) ________ - _________ Work#: (______) ________ - _________

Date of Birth: ______/______/_________ Age: ________ SS#: ________-______-________ Sex: □Male □Female

E-mail: ____ Driver's License #: _____________________________

Occupation: _________________________________ Employer: ____

Status: □ Married □ Single □ Domestic Partner □ Widowed □ Divorced □ Separated

Name of emergency contact: _______________________________________ Phone#: (______) ________ - _________

FORM OF PAYMENT □ CASH □ CHECK (*Payable to Accident & Injury Chiropractic*) □ VISA / MC □ CARE CREDIT

Are you insured? □ YES □ NO

Primary Insurance: ____

Insured's Name: ___________________________________ Insured's Date of Birth: Date: ______/______/__________

Insured's ID #: ____ Group #: ______________________________

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that *Raymond Chiropractic, Inc.* will prepare any necessary forms and reports to assist me in making collection from the insurance company and that any amount authorized to be paid directly to *Raymond Chiropractic, Inc.* 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 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 me will be immediately due and payable.

It is understood and agreed the amount paid the doctor, for x-rays, is for examination only and the x-ray negatives will remain the property of the office, and may be released with a written notification and 15 days notice.

Patient / *Guardian* Signature _______________________________________ Date _________/_________/___________

Printed Name ____

Relations to Minor (*If Guardian*) _______________________________________

PAST HEALTH HISTORY

Name: ____Date: ______/______/__________

Major Surgery/Operation(s): □ Back Surgery □ Broken Bones □ Neck Surgery

Other: ____

Major Accident(s) or Fall(s): ____

Hospitalization(s) (*Other than above*): ____

Name of your Medical Doctor: ______________________________________ Phone#: (______) ________ - _________

Address: ____

Previous Chiropractic Care: □ None □ Yes –

Doctor's Name: ____

Approximate Date of last visit: ______/______/__________

CURRENT HEALTH CONCERNS

Height: ________'________" Current Weight: __________

My current health concerns are from: □ Auto Collision □ Work Injury □ Other: ____________________________

Major Complaints:

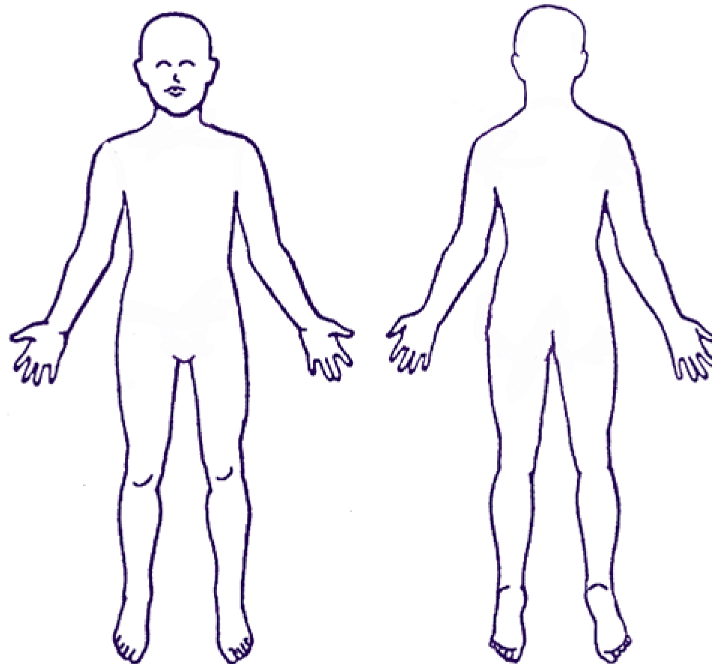
A. ____ D. ____

B. ____ E. ____

C. ____ F. ____

Comments:

PLEASE OUTLINE ON THE DIAGRAM THE AREAS OF YOUR DISCOMFORT



Name: ____Date: ______/______/__________

HOW DID YOU HEAR ABOUT OUR OFFICE?

□ Attorney: Name ____ Phone#: (_______) ________ - __________

□ Health Fair

□ Insurance Provider Manual

□ Internet: □ Google □ Office Website

□ Other Website: ____

□ Location: □Office sign □ Drive-by □Walk-in

□ Patient: Name ____ Phone: (_______) ________ - __________

□ Phonebook

□ Physician: Name ____ Phone: (_______) ________ - __________

□ Workshop / Lecture

□ Other: ____