



Patient Information Form

First Name _____ Middle _____ Last _____
Phone: Home _____ Office _____ Cell _____
Street _____ City/Town _____ State _____ Zip Code _____
Age ___ Sex ___ Birth Date ___ / ___ / ___ Marital Status (S M W D) Spouse's Name _____
Social Security # _____ Occupation _____ Employer _____

I do not have any medical Insurance. (signature) _____ Date _____

Insurance Information:

Company _____ Policy# _____ Group# _____
Policy holder: _____ Relationship to patient: _____ Policy holder DOB: _____

Company _____ Policy# _____ Group# _____
Policy holder: _____ Relationship to patient: _____ Policy holder DOB: _____

What is your major complaint? _____ When did this begin? _____

Is this condition due to an auto accident? Y N If yes, date of accident _____

Are your symptoms: Improving Getting worse About the same Intermittent

Have you had these symptoms before? Y N If yes when _____

Have you seen another doctor for this condition? Y N

If yes, whom? M.D. Chiropractor ER Physical Therapy Massage Therapy

Drs. name _____ Date Consulted ___ / ___ / ___ Diagnosis _____

Drs. name _____ Date Consulted ___ / ___ / ___ Diagnosis _____

Height ___ ft. ___ in. Weight _____ lbs. Have you had any recent weight changes? Y N

Do you use tobacco? Y N Second hand smoke exposure Y N

Have you been diagnosed with: High Blood Pressure, Diabetes, Asthma, Tumors,
 Lupus, Rheumatoid, Fibromyalgia, Other _____

List any traumas and dates: _____

List any surgeries and dates: _____

List any medications you are currently taking: _____

Medication allergies: _____

I understand and agree that health and accident insurance policies are agreement between me and my insurance carriers. I authorize payment from my insurance carrier directly to this office with the understanding that all monies will be credited to my account upon receipt. However, I understand and agree that services rendered are charged directly to me and that it is my responsibility to see they are paid. In the event of default I promise to pay any collection cost and reasonable attorney fees as may be required to effect collection. Full payments for services is due before services are rendered. If for any reason this request cannot be met, arrangements must be made in advance of seeing the doctor.

Patient's Signature _____ Date _____

York Spinal Care

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