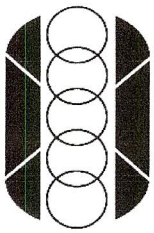

Patient Information Form

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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