DUBLIN FAMILY Chiropractic
6365 Shier Rings Rd., Ste. A, Dublin, OH 43016 p) 614.764.4001 f) 614.764.4002
www.dublinfamilychiropractic.com

Name _____ Date of Birth _____

Address _____ Gender: Male_____ Female_____

City_____ Cell Phone _____

State_____ Zip_____ Email Address_____

Social Security Number _____-____-_____ Marital Status: Sin__ Mar__ Div__ Sep__ Wid__ Other__

Employer _____ Occupation _____

Work Address_____ City_____ Work Phone_____

Emergency Contact:_____

Phone number:_____ **Relation:**_____

Do you have any allergies? (if so please list)_____

Chief Complaint(s):Headache_____ Neck pain _____Mid-Back Pain _____Low Back Pain _____

Numbness/Tingling _____Weakness _____Trouble Breathing _____Can't Move_____

Other_____

How long have you had this condition? _____ Date of injury _____

How did this occur? _____

Sports related? _____ Work Accident? _____ Auto accident? _____

Have you ever received: Chiropractic: Y / N Massage Therapy: Y / N Acupuncture: Y / N

When?_____ Doctor/Therapist? _____

Condition you were treated for? _____

How did you hear of our office? _____

(If referred, please list the person's name so we may Thank them appropriately!)

I authorize Dublin Family Chiropractic, Inc. to release any medical information necessary to bill my account to my insurance company or its authorized representative, Workers' Compensation, or attorney. I authorize payment of my medical benefits directly to Dublin Family Chiropractic, Inc. I understand that I am financially responsible for charges not covered by this authorization.

I certify I will pay Dublin Family Chiropractic, Inc. any co-payments, co-insurance, deductibles, or cost of non-covered products or services. I will promptly pay to Dublin Family Chiropractic, Inc. any payments that I receive from my insurance carrier for services provided to me and/or my dependents. I will also be responsible for any amounts not paid by insurance if I fail to provide appropriate insurance information for billing.

Your Signature _____ Date _____