CONFIDENTIAL PATIENT INFORMATION DATE _____

Name _____ Phone # _____ Cell # _____

Address _____ City _____ Zip _____

Age _____ Date of Birth _____ Marital Status: M S W D How Many Children? _____

Social Security # _____TDL # _____ Email Address _____

Occupation _____ Employer _____ Work Phone _____

Address _____ City _____ Zip _____

Name of Spouse _____ Occupation _____

Employer _____Work Phone _____

Patient's Nearest Relative _____ Phone # _____

Address _____ City _____ Zip _____

Referred By: _____

Have you ever suffered from:

1. Dizziness: _____	6. Arthritis: _____	11. Digestive Disorders: _____
2. Backaches: _____	7. Headaches : _____	12. Heart Trouble: _____
3. Cancer: _____	8. Numbness: _____	13. Sinus Trouble: _____
4. Diabetes: _____	9. Neuritis: _____	14. Anemia: _____
5. Hernia: _____	10. Asthma: _____	15. Rheumatic Fever: _____

Purpose of this appointment: _____

Other doctors seen for this condition: _____

Current Medications: _____

Have you been treated by a physician in the last year? YES NO Describe _____

Is this condition due to injury or illness arising out of employment? YES NO If yes, Please fill out the back of this form.

Is this condition due to injury or illness arising out of an auto accident ? YES NO If yes, Please fill out the back of this form.

Date of Injury: _____ Date symptoms first appeared: _____

Number of days lost from Work: _____ Have you ever had same or similar symptoms? YES NO

PAYMENT IS EXPECTED AT THE TIME OF VISIT

Name of person responsible for payment: _____

Are you insured? YES NO Name of Insurance Company: _____

Address _____ City _____ ST _____ Zip _____

Phone #: _____ Group #: _____ Policy #: _____

Relationship to Insured: SELF SPOUSE CHILD

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that Jones Rd. Chiropractic will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to Jones Rd. Chiropractic will be credited to my account on receipt. However, I clearly understand and agree that any services rendered me are charged directly to me and that 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.

Patient's Signature: _____ Date: _____

Guardian's Signature: _____ Date: _____