Confidential Patient Information

*PLEASE PRINT IN **INK***

(If you are completing this form on behalf of a minor, please include Occupation information for the Parent or Guardian)

Date _____

Name _____ Home Phone # _____ CellPhone # _____

Street Address _____ Apt # _____

City _____ State _____ Zip Code _____

SSN _____ Marital Status: S__ M__ D__ W__ Age ____ Birth Date _____

Occupation _____ Employer _____ Work Phone # _____

Employer's Address _____ City _____ State ____ Zip _____

E-mail: _____ Do we have permission to call your home? Y N work? Y N cell? Y N

Would you like to receive our quarterly natural health e-newsletter? Y N

Spouse's Name_____ Occupation _____ Employer _____

Emergency Contact or Nearest Relative (not living at home) Name/Address/Phone _____

_____

Referred by_____

Have you ever suffered from:

___ Dizziness	___Backaches	___Heart Trouble	___Tuberculosis	___Digestive Disorder
___Hypertension	___Headaches	___Asthma	___Neuritis	___Orthopedic Problem
___Sinus Trouble	___Anemia	___Diabetes	___Rheumatic Fever	

History

What is your major complaint?_____

_____

Date of Onset _____

Other doctors seen for this condition_____

Have you been treated for any health condition by a physician in the last year?_____

If yes, describe_____

Remarks and additional information_____

_____

_____

Insurance Information

Are you covered by Medicare? ___Yes ___No Medicare # _____

Do you have health insurance? ___Yes ___No Name of insurance company _____

Name of insured _____ Group #_____ ID # _____

Birthdate _____ SS# _____ Insured's Home phone _____

Insured's Address _____ City, State, Zip _____

Insured's relationship to patient _____

Occupation of Insured _____ Employer _____

Insured's Work Address _____ City, State, Zip _____

Insured's Work Phone (_____)_____

Payment is expected at time of visit.

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that this chiropractic office 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 this chiropractic office 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 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 to me will be immediately due and payable.

I authorize Victoria Snelling, D.C. and whomever she designated as her assistants to administer treatment as she deems necessary to my child, _____ as of _____.

(child's name) (date)

_____ _____

Signature of Patient or Parent Signature of Witness