NEW PATIENT APPLICATION

Welcome to our Practice! Please thoroughly complete all questions. Thank you.

Name: ____ Today's Date: ________________

Address: ____

City/State/Zip: ____ E-Mail: _____________

Phone: Home: ___________________ Cell: ___________________ Work: ___________________

Marital Status: M/W/D/S

Birthdate: ___/___/___ Age: _______ Social Security #: ______________________________

Whom may we thank for referring you? ____

Your prior Doctor of Chiropractic: ____
and address____

Chiropractic techniques you've had success with: _______________________________________

Last time you went to previous Doctor of Chiropractic: ___________________________________

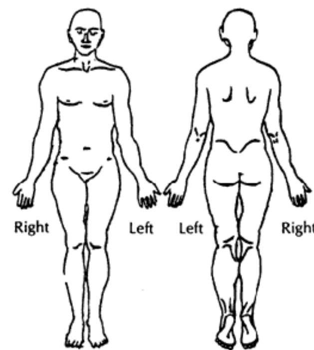
General Practitioner: ___________________________ and City ___________________________

Your Employer: _______________________________ Phone Number ( ) ________________

Employer's Address: ____

Occupation: ________________________________

Mark areas of Health Concerns



Spouse's Name: ______________________________

Spouse's Employer: ___________________________

Children's Name & Ages: ______________________
____

Favorite Hobbies or Interests: __________________
____

Health Reasons for Consulting Our Office:
1. _____________________________________ 3._____________________________________
2. _____________________________________ 4. _____________________________________

Have you had the same or similar problem(s) before? _____ Yes _____ No
How Long?:__________ Please Explain: ____
____

Father/Mother/Brother/Sister/Children, with similar problems?___________________________
____

Is this the result of an auto or work injury? _____ If so, when? ___________________________

If this is a work injury, is there a panel chiropractor that your company's Worker's Compensation
Insurance requires you to see in the first 90 days? If so, please list their name.
____

Other Doctors who have treated this problem: ____
____

Surgery you have had: ____

Medication(s) you currently take: ____

Is there any chance you are pregnant? Yes _______ No _______

What have you heard about chiropractic? ____
____

Do you know what a subluxation is?_____ If yes, please describe __________________________
____

What daily rituals for spinal health do you presently practice? ___________________________
____

Have you ever been diagnosed with cancer? ____ If so, what kind? _______________________
____

Do you have health insurance? _____ Name of Company: ___________________________________
I.D. #_________________________ Group #____
Name of Insured ____

Method of Payment for First Visit: _____ Cash _____ Check _____Credit Card

I understand and agree that health and accident 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 on 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. If I fail to pay for services rendered and you are required to institute collection proceedings, I agree to pay for reasonable attorney's fees and costs in attempting to collect the balance. 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 or Spouse's Signature ____