Patient Information

Total Health Chiropractic

Name ____

Address ______________________ City ______________ State ______ Zip ______

Home Phone ______________________ Cell Phone ______________________

E-mail ______________________ Future appointment reminder by: Text_____or Voicemail ______

Age__________ Date of Birth ______________ Marital Status: M S W D How many children __________

Occupation ______________________ Employer ______________________

Address ______________________ Work Phone ______________________

Name of Spouse ______________________ Employer ______________________

Occupation ______________________ Work Phone ______________________

Patient's Nearest Relative ______________________ Phone ______________________

Referred by ______________________ Date of Last Physical Exam ______________________

Have you ever suffered from:

Headaches	☐ Yes	☐ No	Arthritis	☐ Yes	☐ No
Backaches	☐ Yes	☐ No	Dizziness	☐ Yes	☐ No
Neck Pain	☐ Yes	☐ No	Asthma	☐ Yes	☐ No
Arm Pain	☐ Yes	☐ No	Digestive Disorders	☐ Yes	☐ No
Lower Back Pain	☐ Yes	☐ No	Nervousness	☐ Yes	☐ No
Leg Pain	☐ Yes	☐ No	Sinus Trouble	☐ Yes	☐ No
Heart Trouble	☐ Yes	☐ No	Anemia	☐ Yes	☐ No
Diabetes	☐ Yes	☐ No	Cancer	☐ Yes	☐ No
Tuberculosis	☐ Yes	☐ No	Stress	☐ Yes	☐ No

Any symptoms other than the above ______________________

Other doctors seen for this condition ______________________

Have you been treated for any health condition by a physician in the last year ☐ Yes ☐ No

Describe ______________________

Primary Healthcare Physician (PCP) ______________________ Phone ______________

Any family history of disease or illness ______________________

Are you pregnant ☐ Yes ☐ No. List any medications:______________________

Do you smoke ☐ Yes ☐ No Do you drink alcohol ☐ Yes ☐ No Do you use drugs ☐ Yes ☐ No

PAYMENT IS EXPECTED AT TIME OF VISIT

Name of person responsible for payment ______________________

Are you insured ☐ Yes ☐ No Company ______________________ Phone ______________

I consent to treatment as necessary or desirable to the patient first named above. I also acknowledge full responsibility for the payment of such services and agree to pay for them in full, at the time of service, unless other arrangements are made. I further agree if this account be placed in the hands of any attorney or collection agency for collections, I will be responsible for all reasonable collection, attorney and/or court fees. I hereby assign to this office, my rights to receive payments from negligent parties or from insurance companies. I hereby authorize the release of any medical or other information to process claims for payment. I hereby authorize and direct my attorney to pay directly to Total Health Chiropractic such sums as may be due and owing for medical service rendered me both by reason of this accident and by reason of any other bills that are due this office and to withhold such sums from any settlement, judgment or verdict as may be necessary to adequately protect and fully compensate said doctor. Payments should be payable to and mailed to: Total Health Chiropractic

Patient's Signature ______________________ SS# ______________ Date ____________

Guardian's Signature ______________________ SS# ______________ Date ____________

Attorney's Signature ______________________ Date ____________