CONFIDENTIAL PATIENT INFORMATION

Social Security Number _____ Today's Date _____

Name _____ Telephone # (home) _____

Mailing Address _____ Telephone # (cell) _____

City _____ State _____ ZIP _____ - _____ Marital Status: S M D W

Birth Date _____ Age _____ Gender: F M Number of children _____

Employer _____ Occupation _____

If married, spouse's name _____ Spouse's Birth Date _____

Name of nearest relative NOT living with you _____ Telephone # _____

Mailing Address _____ City _____ State _____ ZIP _____

Referred to our office by _____ Date of last medical or chiropractic exam _____

Do you suffer from:	YES	NO		YES	NO		YES	NO
Dizziness	_____	_____	Asthma	_____	_____	Anemia	_____	_____
Headaches	_____	_____	Arthritis	_____	_____	Nervousness	_____	_____
Sinus problems	_____	_____	Cancer	_____	_____	Tuberculosis	_____	_____
Backaches	_____	_____	Diabetes	_____	_____	Digestive disorders	_____	_____
Nerve pain / numbness	_____	_____				Heart Trouble / Pacemaker	_____	_____

Purpose of this appointment _____

_____

Other health care providers seen for this condition _____

Has a physician treated you for any health condition in the last year? YES _____ NO _____ Whom? _____

Describe _____

Remarks and any additional information _____

PAYMENT IS EXPECTED AT THE TIME OF VISIT

Name of person responsible for payment _____

Name of Health Insurance Company _____

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and the in sured. I understand that Total Health Chiropractic will prepare necessary reports and forms to assist in collection from the insurance company and that any amount authorized to be paid directly to Total Health Chiropractic will be credited to my account upon receipt. However, I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment.

Patient's Signature _____ Date _____

Guardian's signature if under 18 _____ Date _____

Patient Information

E-mail Address: _____

We want to keep you informed of your health. We will send your visit summary to your office portal. You may access this by activating your portal here in the office. We will be happy to help with this.

Height _____

Weight _____

Smoking Status?

- ☐ Current every day smoker
- ☐ Current some day smoker
- ☐ Former smoker
- ☐ Never smoker

Current Medications:

( ) Not currently prescribed any medications

( ) Yes….

_____ _____ mg

_____ _____ mg

_____ _____ mg

_____ _____ mg

_____ _____ mg

_____ _____ mg

_____ _____ mg

Medication Allergies:

( ) No known medication allergies

( ) Yes…

_____

_____

_____

_____

_____

_____

_____