ABOUT YOU

Today's Date:/		File #: _				
Patient Name:		FIRS	T MI			
What You Prefer To Be (Called:		🗅 Male 🖵 Female			
Birthdate: ////	Age:	SS#:				
Mailing Address:	_					
CITY Home Phone #:		STATE	ZIP			
Work Phone #: Ext:						
Other Phone #s:						
E-Mail Address:						
Referred By:						
Employer: How Long?						
Employer's Address:						
CITY		STATE	ZIP			
Occupation:						
Status: Minor Single Married Divorced Separated Widowed						
Spouse's Name:						
Do you have children?	Yes 🗅 No	How	v many?			



I	NJURANCE IN	F0
Co. Name:		
Address:		
CITY	STATE	ZIP
Phone #:		
Insured's ID#:		
Group # (Plan, Local, or Policy	#):	
Insured's Name:		
Relation:	Date of Birth:/	/
Insured's Employer: Please inform front desi	k of 2nd. Insurance source.	

REASON FOR VISIT

The r	reason	for	this	visit	is a	result	of (Please	circle):	work,	sports,	auto,	trauma	or	chronic
(Eynl	lain wh	at h	ann	anar	1.										

Please describe the pain & its location: ___

When did condition begin? / /

Is this condition getting worse? Yes No Constant Comes and goes Is this condition interfering with your (Please Circle): work, sleep, or daily routine. If so, please explain:

Have you had this or similar conditions in the past? Q Yes Q No

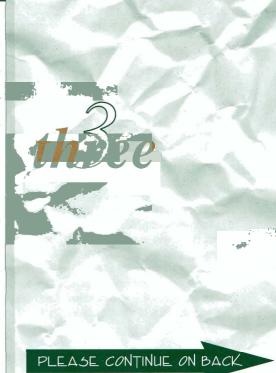
If so, please explain:

Have you been treated by a Medical Physician for this condition? If so, where?_

Have you ever been treated by a Chiropractor before? Q Yes Q No

If so, whom?__

Phone#:



IN EVENT OF EMERGENCY

Who should we contact?

Relation:

Home Phone #:

Work Phone #:_

Who is your Medical Doctor?_

Phone #:

HEALTH HISTORY									
Are you taking any of the following medications?	f								
□ Nerve pills □ Pain killers (including aspirin) □ Muscle relaxers □ Stimulants									
□ Blood Thinners □ Tranquilizers □ Insulin □ Other(s) Do you have or ever had any of the following diseases or conditions?	1								
Y N Heart Attack / Stroke Y N Heart Surg./Pacemaker Y N Heart Murmur	Seame .								
Y N Congenital Heart Defect Y N Mitral Valve Prolapse Y N Artificial Valves									
Y N Alcohol / Drug AbuseY N Venereal DiseaseY N HepatitisY N HIV+ / AidsY N ShinglesY N Cancer									
Y N Frequent Neck Pain Y N Emphysema / Glaucoma Y N Anemia									
Y N High/Low Blood PressureY N Psychiatric ProblemsY N Rheumatic FeverY N Severe/Frequent HeadachesY N Kidney ProblemsY N Ulcers / Colitis									
Y N Fainting/Seizures/Epilepsy Y N Sinus Problems Y N Asthma									
Y N Diabetes / Tuberculosis Y N Difficulty Breathing Y N Chemotherapy									
Y N Lower Back ProblemsY N Artificial Bones / JointsY N ArthritisPlease list any other serious medical condition(s) you have or ever had:		ACCOUNT INFO							
	1								
	States.	on ultimately responsible for account							
Please list anything that you may be allergic to:	Nam	e:							
	Rela	tion:							
List previous surgeries/treatments with dates:	Billin	Billing Address:							
	13-								
List any past serious accidents with dates:	CITY								
	SSN:								
	D.L.#	·							
Family Health History:	100 million (100 m	Phone#:							
	Paym	nent method: CASH Check							
Do you: Take Supplements or Vitamins? □Yes □ No / Exercise? □Yes □ No									
Are you on a special diet:	Cre	dit Card - Enter card # above (if accepted)							
Do you smoke? Do No D Yes / How Much? How Long?	Initia	I hereby authorize assignment of							
Are you wearing: Define Heel Lifts Definition Sole lifts Definition Inner soles Definition Arch supports		^{IIs} my insurance rights and benefits tly to the provider for services ren-							
What is the age of your mattress? Is it comfortable?	derec	I. I fully understand I am solely respon-							
For women: Are you taking Birth Control? Yes No		for any balance not paid by my insur- company (if offered at this office).							
Are you Pregnant? D No D Yes/How long? Nursing? D Yes D No	ST.								
We invite you to discuss with us any questions regarding our services. The best health services are based on a friendly, mutual									

Our policy requires payment in full for all services rendered at the time of visit, unless other arrangements have been made with

the business manager. If account is not paid within 90 days of the date of service and no financial arrangements have been made, you will be responsible for legal fees, collection agency fees, and any other expenses incurred in collecting your account.
 I authorize the staff to perform any necessary services needed during diagnosis and treatment. I also authorize the provider

and or managed care organization, to release any information required to process insurance claims.

I understand the above information and guarantee this form was completed correctly to the best of my knowledge and

I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes to the information I have provided.

Signature _

 the second se		
Adult Patient	Parent or Guardian	Snouse
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Date / /

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