# Confidential Patient Information
## Case History

Name _____Date _____
E-mail Address_____ Phone #_____ Cell #_____
Address_____
City _____ State_____ Zip _____
Age_____ Birth Date_____ Marital Status: M S W D
Occupation _____Employer _____
Address_____ Office Phone _____
Student at _____Full Time ___Part Time ___
Name of Spouse _____ Occupation _____
Employer _____ Address _____
Name of Nearest Relative _____
Address_____ Phone _____
How did you hear about our office?_____

Purpose of this appointment _____
Other doctor seen for this condition _____ Ph. # _____
Have you been treated for any health condition by a physician in the last year? YES NO
Describe_____
Do you currently or have you had any major illnesses or conditions? _____
_____
If you are a female are you pregnant or trying to become pregnant?_____
What medications or supplements are you taking? _____
_____
_____
Primary Care Physician _____ Ph. # _____
_____

I understand and agree that health and accident insurance policies are an arrangement between my insurance company and myself – not between my insurance company and this office. I authorize this chiropractic clinic to release any medical information and to complete any usual and customary reports and forms at no charge to assist in collecting from my insurance company.
If mine is a regular health insurance case, I agree to pay a percentage of services as they are rendered. However, I understand that I am ultimately responsible for payment in full at this office. I also understand that if I suspend or terminate my schedule of care as determined by my treating doctor, any fees for professional services will be immediately due and payable. If payment is not received after 30 days of receiving bill interest will accrue at 18 percent per annum.

Patient's Signature _____ Date _____

Guardian's Signature Authorizing Care _____Date _____