CONFIDENTIAL PATIENT INFORMATION

NAME:____**HOME PHONE:**__________________________

ADDRESS:______________________________________**CELL PHONE:**____________________________

CITY:______________________**ZIP CODE:**__________**BIRTHDATE:**________________**AGE:**________

E-MAIL____**SS#**____
May we use e-mail for Gardner Chiropractic newsletters or for scheduling purposes? Yes___ No___

MARITAL STATUS: M S W D SEX: M F HOW MANY CHILDREN_________

OCCUPATION_________________________________**EMPLOYER**_______________________________

ADDRESS EMPLOYER__________________________**OFFICE PHONE**___________________________

SPOUSE___________________________________**OCCUPATION**_________________________________

EMPLOYER_______________________________**OFFICE PHONE**________________________________

****EMERGENCY CONTACT**______________________________**PHONE**___________________________

REFERRED BY______________________________

CHECK IF YOU HAVE YOU EVER SUFFERED FROM:

Dizziness	_______	**Asthma**	______	**Stroke**	______
Backaches	_______	**Neuritis**	______	**Tingling into arms**	______
Heart Trouble	_______	**Digestive Disorders**	______	**Tingling into legs**	______
Diabetes	_______	**Nervousness**	______	**Anemia**	______
Tuberculosis	_______	**Sinus Trouble**	______	**Cancer**	______
Arthritis	_______	**Headaches**	______		

Purpose of your appointment?____

When did your condition first appear?____

What makes it better?____

What makes it worse?____

Does the pain travel into your arms and legs?____

What percentage of the day is the condition present?____________________________________

Have you ever been seen by a chiropractor?____

When was the date of your last physical exam?____________________**last x-rays?**____________________

Have you been treated for any health conditions by a physician in the last year?______________________

____

List medications:____

List supplements:____

List allergies:____

Past medical history:____

Family history of disease:____

Do you drink alcoholic beverages, if so how many per week:_______________

Do you smoke, if so how many per week:________________________________

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PAYMENT IS EXPECTED AT TIME OF VISIT.
Person responsible for payment___________________________________
Insurance Company____

I understand and agree that health and accident insurance policies are agreement between an insurance carrier and myself. Furthermore, I understand that Gardner Chiropractic 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 Gardner Chiropractic will be credited to my account on 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. 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________________________________**Date**__________________________