NEW PATIENT PRELIMINARY INFORMATION QUESTIONNAIRE

E-Mail _____

Mr.
Patient: Mrs._____ Soc. Sec. No. _____
Ms. (First) (Middle) (Last)

_◉_ Single _○_ Married _○_ Separated _○_ Divorced _○_ Widowed Birth Date: _____

Home Address: _____
(Street) (City) (State) (Zip)

Home Phone: _____ Cell Phone: _____

Patient Employed By: _____ Occupation: _____

Business Address: _____ Business Phone: _____
(Street) (City) (State) (Zip)

Name of Spouse: _____ Soc. Sec. No._____

Spouse Employed By: _____

List name, address and phone number of one relatives not living with you: _____

_____

Referred By:_____

Who is responsible for this account? _____

What are your main problems (pains)? _____

_____

_____

What other health care have you received for this problem? _____

_____

Date of Accident/Beginning of illness: _____ Hour _____ in the _____AM or_____ PM

Location of Accident: _____

How did it occur? _____ Auto Collision _____ On-the-job _____ Other: _____

Please describe the circumstances: _____

_____

Have you lost time from work? _____ YES _____ NO If YES, please give dates: _____

_____

FEMALE: Are you Pregnant? _____ YES _____ NO Number and Ages of Children: _____

_____

IS THIS CASE COVERED BY INSURANCE? _____ YES _____ NO

PLEASE INDICATE WHICH INSURANCE YOU HAVE:

GROUP INSURANCE: _____ BLUE CROSS/BLUE SHIELD: _____ WORKER'S COMPENSATION: _____

AUTO INSURANCE: _____ MEDICARE: _____ PERSONAL INJURY: _____ OTHER INSURANCE: _____

Office Policies

- If you can not make your appointment please call 24 hours prior to appointment time.
- There is a **$25 fee** for all appointments that are cancelled or re-scheduled after given time.

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that this Chiropractic office 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 this Chiropractic Office will be credited to my account on receipt. However, I clearly understand and agree that all service rendered to me and 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 service rendered to me will be immediately due and payable.

Signature _____ Date _____

(If patent is a minor, name of parent, guardian, etc.)