CONFIDENTIAL PATIENT INFORMATION DATE:_____

NAME:_____SS#:_____HM PHONE:_____

ADDRESS:_____CITY/ZIP:_____

AGE:_____BIRTH DATE:_____STATUS: M S W D HOW MANY CHILDREN:_____

E-MAIL ADDRESS:_____CELL PHONE:_____

OCCUPATION:_____EMPLOYER:_____

NAME OF SPOUSE:_____OCCUPATION:_____

EMPLOYER:_____WK PHONE:_____

PATIENT'S NEAREST RELATIVE:_____ HM PHONE:_____

ADDRESS:_____

REFERRED BY: ☐ PHONE BOOK ☐ PAPER ☐ RELATIVE OR ☐ FRIEND -NAME:_____

DATE OF LAST PHYSICAL EXAM (IF UNSURE GIVE APPROX. DATE):_____

HAVE YOU EVER IN YOUR LIFETIME SUFFERED FROM: (CIRCLE YES OR NO)

DIZZINESS	Y	N	ARTHRITIS	Y	N	NERVOUSNESS	Y	N
BACKACHES	Y	N	HEADACHES	Y	N	SINUS TROUBLE	Y	N
HEART TROUBLE	Y	N	ASTHMA	Y	N	DIGESTIVE DISORDERS	Y	N
NEURITIS	Y	N	ANEMIA	Y	N	RHEUMATIC FEVER	Y	N
TUBERCULOSIS	Y	N	DIABETES	Y	N			

IF YOU ARE BEING SEEN FOR INJURIES RESULTING FROM AN AUTO ACCIDENT OR WORK INJURY-PLEASE FILL OUT THE REVERSE SIDE ALSO. WHAT ARE YOU BEING SEEN FOR TODAY?:_____

OTHER DOCTORS SEEN FOR THIS CONDITION? Y N (IF YES-STATE NAME):_____

HAVE YOU BEEN TREATED FOR ANY HEALTH CONDITION BY A PHYSICIAN IN THE LAST YEAR? Y N

IF YES DESCRIBE:_____

PAYMENT IS EXPECTED AT TIME OF VISIT! PLEASE GIVE US ANY INSURANCE INFORMATION YOU HAVE SO THAT YOUR ELIGIBILITY AND COVERAGE LIMITS CAN VE VERIFIED WHLE YOU ARE HERE

NAME OF PERSON RESPONSIBLE FOR PAYMENT (USUALLY THE INSURED ON POLICY):_____

ARE YOU INSURED? ☐ NO ☐ YES - COMPANY:_____

PLEASE READ THE FOLLOWING:

I UNDERSTAND AND AGREE THAT HEALTH AND ACCIDENT INSURANCE POLICIES ARE AN ARRANGEMENT BETWEEN AN INSURANCE CARRIER AND MYSELF. FURTHERMORE, I UNDERSTAND THAT THE JONES 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 THE JONES CHIROPRACTIC OFFICE 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. 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.

PRIVACY NOTICE DISCLOSURE

OUR OFFICE MAY USE AND DISCLOSE YOUR PROTECTED HEALTH INFORMATION IN ORDER TO BILL AND COLLECT PAYMENT FOR TREATMENT AND SERVICES PROVIDED TO YOU. PLEASE ACKNOWLEDGE BY SIGNING BELOW.

PATIENT SIGNATURE:_____DATE:_____

GUARDIAN SIGNATURE:_____DATE:_____

INFORMATION TAKEN BY:_____DATE:_____