

Confidential Patient Information

Chiropractic Spinal Center | 1930 Pearl Rd. #2 Brunswick, OH 44212 | Phone (330) 220-2001 FAX (330) 220-2232

Date _____ Age _____ D.O.B. (Mo/Day/Year) _____ Sex _____ Marital Status _____

First & Last Names _____ E-mail _____

Street Address _____ Apt# _____ City _____ State _____ Zip Code _____

Phone (_____) _____ Work Phone (_____) _____ Social Sec # _____

Occupation _____ Employer _____ Location _____

Guardian/Spouse's Full Name _____ D.O.B. _____ Social Sec # _____

Occupation _____ Employer _____ Location _____

Name, work phone and city of nearest relative (not your spouse): _____

Were you referred to a certain doctor in this office? _____ Is your visit due to an accident? No Yes

YOUR PRESENT COMPLAINT(S)

List other doctor(s) seen for this condition: _____

Personal Medical history (if any of the following are relevant to your medical history, please check the accompanying box)

- | | | | |
|--|---|--|--|
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Muscular Dystrophy | <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Digestive Disorders |
| <input type="checkbox"/> Polio | <input type="checkbox"/> Multiple Sclerosis | <input type="checkbox"/> Scarlet Fever | <input type="checkbox"/> Sinus Trouble |
| <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Convulsions | <input type="checkbox"/> Nervousness | <input type="checkbox"/> Backaches |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Asthma | <input type="checkbox"/> Numbness |
| <input type="checkbox"/> Heart Trouble | <input type="checkbox"/> Concussion | <input type="checkbox"/> Dizziness | <input type="checkbox"/> High Blood Pressure |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> German Measles | <input type="checkbox"/> Venereal Disease |

Describe any operations you've had and the dates: _____

Have you been treated by a physician for any health condition in the last year? Yes No

Describe Condition _____ Date of last physical exam _____

Are you now taking any medication? Yes No. What kind? _____

Are you allergic to any medication? Yes No. What kind? _____

Are you pregnant? Yes No. Date of last menstrual period: _____

Do you have insurance? Yes No. Company _____ I.D. No. _____ Policy Group No. _____

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that this 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 office will be credited to my account upon receipt. I permit this office to endorse co-issued remittances for the conveyance of credit to my account. However, I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. It is my understanding that my credit may be checked if Chiropractic Spine Center extends credit to me and I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered to me will be immediately due and payable unless prior arrangements are made. I hereby authorize the doctors at Chiropractic Spine Center and whomever they may designate as their assistants to administer treatment as they so deem necessary and I also authorize the release of any information acquired in the course of my examination or treatment. I certify that the above information is true and correct.

Patient's (Parent or Guardian's) Signature _____