CONFIDENTIAL PATIENT INFORMATION

Woodcrest Chiropractic Offices

Name:______________________________ Home#:____________ Cell#:___________

Address:_______________________________ City:____________ Zip Code:__________

Age:____ Birthdate:__________________ Marital Status: M S W D

Driver's License # __________________ Gender: M F No. Of Children:______

SSN:_____________________ Occupation: ____________________________________

Employer:______________ Address:________________________ Work#: ____________

Bank:_________________ Branch:________________ Account#:__________________

Name of Spouse:____________________ Occupation:____________________________

Patient's Nearest Relative:_____________________ Phone#:______________________

Date of Last Physical Examination:____

Referred by:____

Have you ever suffered from:

Dizziness	Y	N	Asthma	Y	N
Backaches	Y	N	Neuritis	Y	N
Heart Trouble	Y	N	Digestive Disorder	Y	N
Diabetes	Y	N	Nervousness	Y	N
Tuberculosis	Y	N	Sinus Trouble	Y	N
Arthritis	Y	N	Anemia	Y	N
Headaches	Y	N	Rheumatic Fever	Y	N

Purpose of Appointment:____

Other Doctors seen for this condition:_______________________________________

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

Y N If yes, please describe:____

Remarks and Additional Information:_________________________________

PAYMENT IS EXPECTED AT TIME OF VISIT

Name of person responsible for payment:_____________________________________

Are you insured? Y N Company: ___________________________________

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. I understand that Woodcrest Chiropractic Offices 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 Woodcrest Chiropractic Offices will be credited to my account on receipt. 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. 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.

<u>A MONTHLY INTERST OF 2% WILL BE ADDED TO UNPAID BALANCES</u>

Patient's Signature: ____________________________________ Date: ___________

Guardian or Spouse's Signature:__________________________ Date:____________

Information Taken By:____________________________________ Date:____________