FIRST CHOICE CHIROPRACTIC
INJURY & WELLNESS CENTER
Welcomes You

Patient Information

Date _____

Patient: _____

Patient prefers to be called: _____

Address: _____

City _____ State _____ Zip _____

Northern Address: _____

City _____ State _____ Zip _____

Sex: ❑ M ❑ F Age _____ Birthdate _____

❑ Single ❑ Married ❑ Widowed ❑ Separated ❑ Divorced

Patient SS#: _____

Occupation: _____

Employer: _____

Spouse's Name: _____

I give your office permission to discuss my medical information with the following individuals:

Name _____ Relationship _____

Phone#: _____

Name _____ Relationship _____

Phone#: _____

Insurance

Primary Insurance Carrier: _____

Name of Insured (Guarantor): _____

Guarantor D.O.B. _____/_____/_____

Relationship to Patient: _____

Secondary Insurance Carrier: _____

Name of Insured (Guarantor): _____

Guarantor D.O.B. _____/_____/_____

Relationship to Patient: _____

ASSIGNMENT AND RELEASE

I, the undersigned, Certify that I or my dependent, have Insurance coverage with _____ and assign directly to Dr. _____ all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by Insurance. I hearby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Signature _____

Phone Numbers

Home: (___) _____ Work (___) _____ Ext_____

Cell: (___) _____

May we leave medical information on your answering machine or cell phone: ❑ Yes ❑ No

IN CASE OF EMERGENCY, CONTACT:

Name _____ Relationship _____

Phone#: _____

Accident Information

Is condition due to an accident? ❑ Yes ❑ No Date _____

Type of accident ❑ Auto ❑ Work ❑ Home ❑ Other

To whom have you made a report of your accident?

❑ Auto Insurance ❑ Employer ❑ Work Comp ❑ Other

Attorney Name (If applicable) _____

_____

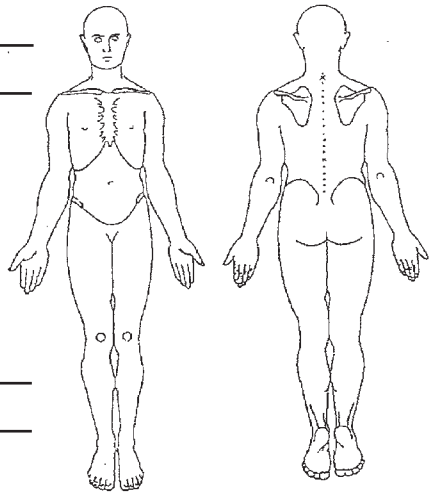
Patient Condition

Reason for visit _____

When did symptoms appear? _____

Is this condition getting progressively worse? ☐Yes ☐No ☐Unknown

Mark an X on the picture where you continue to have pain, numbness or tingling.



Rate the severity of your pain on a scale from 1 (least pain) to 10 (severe pain)

Type of pain: ☐Sharp ☐Dull ☐Throbbing ☐Numbness ☐Aching ☐Shooting ☐Burning ☐Tingling ☐Cramps ☐Stiffness ☐Swelling ☐Other

How often do you have this pain? _____

Is it consistent or does it come and go? _____

Does it interfere with your... ☐Work ☐Sleep ☐Daily Routine ☐Recreation

Activities or movements that are painful to perform: ☐Sitting ☐Standing ☐Walking ☐Bending ☐Lying down