Hofferth Chiropractic Center

Confidential Patient Information

Date ____________________

Name ____________________ (First and Last Names) Sex ___ (M or F) Marital Status ___ D.O.B. ______ (Mo/Day/Yr) Age ___ Home Phone ____________ (Area Code/Number)

Address ____________________ (Include Street type such as St., Ave., etc.) City __________ State ______ Zip Code ______

Social Sec # | Occupation | Company Name | Location | Work Phone Number

Guardian/Spouse's Full Name | Guardian/Spouse's D.O.B. | Guardian/Spouse's Social Sec # | Guardian/Spouse's Employer | Location | Work Phone Number

Name of nearest relative (not your spouse): ____________________ Phone ____________

Who referred you to our office? ____________________

Were you referred to a certain doctor in this office? ____________________

Is your visit due to an accident? ☐ No ☐ Yes (if yes, please see receptionist for an injury report.)

YOUR PRESENT COMPLAINT ____________________

BRIEFLY DESCRIBE YOUR SYMPTOMS ____________________

____

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:)

- ☐ Cancer
- ☐ Polio
- ☐ Tuberculosis
- ☐ High Blood Pressure
- ☐ Heart Trouble
- ☐ Diabetes
- ☐ Muscular Dystrophy
- ☐ Multiple Sclerosis
- ☐ Convulsions
- ☐ Epilepsy
- ☐ Concussion
- ☐ Hepatitis
- ☐ Rheumatic Fever
- ☐ Scarlet Fever
- ☐ Nervousness
- ☐ Asthma
- ☐ Dizziness
- ☐ German Measles
- ☐ Digestive Disorders
- ☐ Sinus Trouble
- ☐ Backaches
- ☐ Numbness
- ☐ Arthritis
- ☐ 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 Hofferth Chiropractic 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 Hofferth Chiropractic 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 ____________________