Please complete FRONT AND BACK

PATIENT INFORMATION

Date ____

Patient Name ____

Address ____

City _________________________ State ______ Zip _________

Sex ☐ M ☐ F Age ________ Birthdate_________________

☐ Married ☐ Widowed ☐ Single ☐ Minor

☐ Separated ☐ Divorced ☐ Partnered for_____ years

Occupation ____

Employer/School _____________________________________

Employer/School Address ______________________________

____

Whom may we thank for referring you? ___________________

CONTACT INFORMATION

Home Phone (_______)__________________

Work Phone (_______)___________________

Cell Phone (_______)_________________ Carrier______________
Please provide cell phone carrier if you would like to receive reminder text messages.

Primary contact ☐ Cell ☐ Home ☐ Work Text Message? ☐ Yes ☐ No

E-mail Address ____

(By providing my e-mail address, I authorize the doctor(s) to contact me)

IN CASE OF EMERGENCY CONTACT

Name__________________________ Phone (_____)__________

Relationship ____

INSURANCE

Subscriber's Name? ______________________________________

Birthdate ________________

Relationship to patient ___________________________________

Insurance Co. ____

Policy ID ________________ Group # __________________

Address of subscriber: ____________________________________

City: ____________________ State: ________ Zip: _________

Is there a secondary health benefit plan? ☐ Yes ☐ No

If yes please list: ______________________________________

Subscriber's name:______________________________________

Date of Birth ____________

ASSIGNMENT AND RELEASE

I certify that I, and/or my dependent(s), have insurance coverage with _______________________ and assign directly to Advanced Chiropractic of Milford 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 authorize the use of my signature on all insurance submissions

The above-named entity may use my health care information and may disclose such information to above named insurance co. and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current plan is completed or until I am no longer a patient.

____
Signature of Patient, parent, or guardian

____
Print name of patient, parent, or guardian

Date _________________ Relationship to Patient_________________

ACCIDENT INFORMATION

Is condition due to an accident? ☐ Yes ☐ No
Date ____________________

Type of accident ☐ Auto ☐ Work ☐ Home ☐ Other

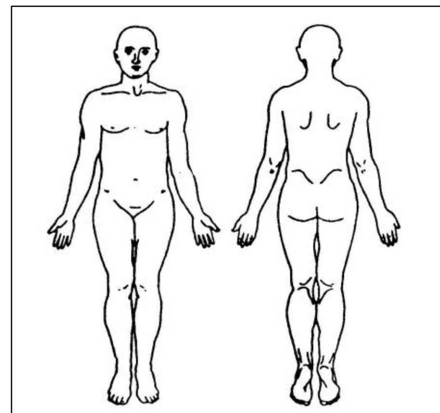
To whom have you made a report of your accident?
☐ Auto Insurance ☐ Employer ☐ Worker Comp ☐ Other

PATIENT CONDITION

Where is your pain? ____

When did your symptoms appear? ______________________________________

Is this condition progressively getting worse? ☐ Yes ☐ No ☐ Unknown
Mark an X on the picture where you have pain, numbness, or tingling



Rate the severity of the 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 constant or does it come and go?__________________________________

Does it interfere with your ☐ Work ☐ Daily routine ☐ Recreation
Activities or movements that are painful to perform ☐ Sitting ☐ Standing ☐ Walking ☐ Bending ☐ Lying Down