EAST MEMPHIS CHIROPRACTIC

Confidential Patient Information

Date:_____

Name: _____ Sex _____ Marital Status _____ DOB _____ Age _____
First and Last Name M or F

Home Phone _____ Mobile Phone _____ Email _____ Driver's Lic # _____
Area Code/Number

Address _____ City _____ State _____ Zip Code _____

_____ _____ _____ _____
Social Security No Business Phone Business Name Location

_____ _____ _____ _____
Spouse's First Name Spouse's Soc Sec No Spouse's Employer Location

Name of nearest relative (not your spouse): _____ Phone: _____

Who referred you to our office? _____

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

YOUR PRESENT COMPLAINT _____

BRIEFLY DESCRIBE YOUR SYMPTONS _____

_____

List other doctor(s) seen for this condition _____

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

☐ Cancer	☐ Muscular Dystrophy	☐ Rheumatic Fever	☐ Digestive Disorders
☐ Polio	☐ Multiple Sclerosis	☐ Scarlet Fever	☐ Sinus Trouble
☐ Tuberculosis	☐ Convulsions	☐ Nervousness	☐ Backaches
☐ High Blood Pressure	☐ Epilepsy	☐ Asthma	☐ Numbness
☐ Heart Trouble	☐ Concussions	☐ Dizziness	☐ Arthritis
☐ Diabetes	☐ Hepatitis	☐ German Measles	☐ 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 ___ _____ _____ _____
Insurance Company Member ID # Policy Group #

_____ _____ _____
Insured's Name Insured's Date of Birth Insured's relation to patient

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 Goode Chiropractic Clinic 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 Goode Chiropractic Clinic and whomever they may designate as their assistants to administer treatment as they so deem necessary and 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 accurate.

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