

CONFIDENTIAL PATIENT INFORMATION

Today's Date _____

Name _____ Date of Birth _____ Age _____

Address _____ City _____ Zip _____

Cell Phone _____ Work _____ Home _____

Marital Status: M S W D How many children? _____ Referred by: _____

SSN# _____ Driver's License #: _____ Email: _____

Occupation _____ Employer _____

Employer Address _____ City _____ Zip _____

Auto Insurance Company _____ Agent's Name _____ Policy # _____

Name of Spouse _____ Occupation _____

Spouse's Employer _____ Office Phone _____

Date of Last Physical Examination _____

Emergency Contact: Name _____ Relationship _____

Address _____ Phone _____

Have You Ever Suffered from:	YES	NO		YES	NO
1. Dizziness	<input type="checkbox"/>	<input type="checkbox"/>	8. Asthma	<input type="checkbox"/>	<input type="checkbox"/>
2. Backaches	<input type="checkbox"/>	<input type="checkbox"/>	9. Neuritis	<input type="checkbox"/>	<input type="checkbox"/>
3. Heart Trouble	<input type="checkbox"/>	<input type="checkbox"/>	10. Digestive Disorders	<input type="checkbox"/>	<input type="checkbox"/>
4. Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	11. Nervousness	<input type="checkbox"/>	<input type="checkbox"/>
5. Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>	12. Sinus Trouble	<input type="checkbox"/>	<input type="checkbox"/>
6. Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	13. Anemia	<input type="checkbox"/>	<input type="checkbox"/>
7. Headaches	<input type="checkbox"/>	<input type="checkbox"/>	14. Cancer	<input type="checkbox"/>	<input type="checkbox"/>

Purpose of this Appointment _____

Other Doctors Seen for this Condition(s) _____

Have you been treated for any health condition by a physician in the last year? YES NO

Describe: _____

Remarks and additional information: _____

PAYMENT IS EXPECTED AT THE TIME OF VISIT!

Name of Person Responsible for Payment _____

Are you insured? YES NO Health Insurance Company: _____

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that Bazil Chiropractic Health Center 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 Bazil Chiropractic Health Center will be credited to my account on receipt. However, I clearly understand and agree that all services rendered 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 me will be immediately due and payable.

Patient's Signature: _____ Date: _____

Guardian or Spouse's Signature: _____ Date: _____