CONFIDENTIAL PATIENT INFORMATION

The following information is needed for our files so we can better serve you as a patient. Please fill in all portions of the form. If you need any help, please ask the receptionist.

DATE _____ WHO REFERRED YOU? _____

PERSONAL DATA

NAME _____ E-MAIL ADDRESS _____

ADDRESS _____ CITY _____ STATE ____ ZIP _____

M / F HOME PHONE ( ) _____ CELL PHONE ( ) _____

S / M / D / W BIRTHDATE _____ AGE _____ _____

NUMBER OF CHILDREN ____ OCCUPATION _____ EMPLOYER _____

NAME OF WIFE OR HUSBAND _____ _____

BIRTHDATE _____ OCCUPATION _____ EMPLOYER _____

NAME OF NEAREST RELATIVE _____ PHONE NUMBER ( ) _____

INSURANCE DATA

INSURANCE NAME _____ MEMBER/ID # _____

IF YOU WOULD LIKE US TO BILL YOUR INSURANCE, PLEASE PRESENT YOUR CARD AT THE FRONT DESK

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 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.

I understand that due to the rising costs of malpractice insurance, and in order to minimize the cost of providing health care services to me, Dr. Steven V. Ray has voluntarily chosen to practice without the benefits of malpractice insurance coverage. I also understand that this is in no way any reflection on his abilities as a Chiropractor and health care provider, nor is it any indication of the quality of the services which I can expect to receive.

I have read and understand the above statements.

PATIENT'S SIGNATURE _____ DATE _____

SPOUSE'S OR GUARDIAN'S SIGNATURE _____ DATE _____

CONFIDENTIAL PATIENT INFORMATION

NAME _____ DATE _____

PRESENT COMPLAINT

IS YOUR VISIT DUE TO ☐ AUTO ACCIDENT ☐ WORK INJURY ☐ OTHER ACCIDENT

DATE OF ACCIDENT / DATE SYMPTOMS FIRST APPEARED _____

BRIEFLY DESCRIBE SYMPTOMS _____

_____

LIST OTHER DOCTORS SEEN FOR THIS CONDITION _____

HAVE YOU BEEN TREATED BY A PHYSICIAN FOR ANY HEALTH CONDITION IN THE LAST YEAR? ☐ YES ☐ NO

WHAT WERE YOU TREATED FOR? _____

MEDICAL HISTORY

(If any of the following are relevant to your medical history, please 'X' the accompanying box.)

☐ GERMAN MEASLES	☐ CONVULSIONS	☐ RHEUMATIC FEVER	☐ SINUS TROUBLE
☐ VENEREAL DISEASE	☐ EPILEPSY	☐ SCARLET FEVER	☐ BACKACHES
☐ MUSCULAR DYSTROPHY	☐ CONCUSSION	☐ NERVOUSNESS	☐ NUMBNESS
☐ MULTIPLE SCLEROSIS	☐ DIZZINESS	☐ ASTHMA	☐ ANEMIA
☐ DIGESTIVE DISORDERS	☐ ARTHRITIS	☐ HEART TROUBLE	☐ CANCER
☐ TUBERCULOSIS	☐ NEURITIS	☐ DIABETES	☐ POLIO
☐ HIGH BLOOD PRESSURE	☐ RHEUMATISM	☐ HEPATITIS	☐ HIV Positive (A.I.D.S.)

DATES & TYPES OF SURGERIES: _____

LIST PRESCRIPTION MEDICATIONS _____

DATE OF LAST PHYSICAL EXAM: _____

ARE YOU PREGNANT? ☐ YES ☐ NO DATE OF LAST MENSTRUAL PERIOD: _____

I certify that the above information is, to the best of my knowledge, complete and accurate.

PATIENT'S SIGNATURE _____ DATE _____

SPOUSE'S OR GUARDIAN'S SIGNATURE _____ DATE _____