HOLLIDAY CHIROPRACTIC CARE

CONFIDENTIAL PATIENT INFORMATION

NAME: Last ________________________________ First ____________________________ M.I. ___________

Address ____________________________________ City _______________________________ State ________

Zip Code ___________________

Phone Number(s): Home ______________________________ Work ___________________________________

Cell ________________________________ Message only ____________________________

Age_____ Date of Birth ________________ Employment Status FULL PART RETIRED UNEMPLOYED

Employer __________________________________ Occupation _____________________________________

Marital Status M S W D Student Status FULL PART NON-STUDENT

Name of Husband, Wife or Significant other ____

Date of Birth ___________________ Employer ____

REASON OF THIS VISIT ____

Level of pain currently: 0 1 2 3 4 5 6 7 8 9 10 Frequency: Seldom Intermittent Frequent Constant

Others seen for this condition: ____________________________________ When _______________________

Family Doctor ____ Last seen ____________________________

Serious conditions treated for in the last year ____

What medications, drugs or supplements are you currently taking? __________________________________

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PAYMENT IS EXPECTED AT TIME OF VISIT

Are you insured? Yes No *IF YES WE WILL COPY THE CARD AT THE FRONT DESK*

Policy Holder ____ Date of Birth _____________

Policy Holder's Employer __________________________________ Cell Number________________________

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that Holliday Chiropractic Care 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 Holliday Chiropractic Care will be credited to my account upon 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 will be **immediately due and payable.**

Patient Signature:____ **Date** ______________________

Guardian/Parent or Spouse Signature:____