

Health First Chiropractic Confidential Information

File # _____

Name _____ Date _____

Address _____ City _____

State _____ Zip _____ Hm Phone _____ Cell Phone _____

Email _____

Sex _____ Marital Status _____ Date of Birth _____ Age _____

Children (# _____) Names and ages of Dependant Children _____

SS# _____ Occupation _____ Employer _____

Employer Address _____ Employer Phone _____

Spouse Name _____ Spouse Employer _____

Name of Nearest Relative Other Than Spouse _____ Phone _____

Who referred you to our office? _____

Were you referred to a certain doctor in our office? _____

Is your visit due to an injury? No Yes *If yes, circle one:* Auto Work Other _____

(If this visit is due to a work or auto injury, please see the receptionist for a special injury form)

List other doctors you use for your health care: _____

Previous Chiropractor(s): _____

List any surgeries with dates: _____

Note any auto accidents with dates: _____

Insurance Information

Do you have insurance? Yes No Company _____

I.D. # _____ Policy Group # _____

I understand and agree that health and accident insurance policies are an agreement 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

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account. However, I clearly understand and agree that all services rendered me are charged directly to me and I am personally responsible for payment. It is my understanding that my credit may be checked if Health First Chiropractic extends credit to me and I understand that if I suspend or terminate care and treatment, any fees for professional services rendered me will be immediately due and paid unless other arrangements are made. I hereby authorize the doctors at Health First Chiropractic and whomever they may designate as their assistants; to administer treatments as they deem necessary and also authorize the release of any information acquired in the course of examination or treatment. I certify that the above information is true and correct.

Patient Signature (Or Parent or Guardian): _____ Date _____