Date______________________________

CONFIDENTIAL PATIENT INFORMATION

Social Security #_____________________

Drivers' License #____________________

Name____ Home Phone__________________________

Address ______________________City_______________ Zip__________ Cell Phone_______________

E-mail address ____ Age ________ Birth Date ______________

Marital Status: M S W D How many children?______________

Occupation __________________________ Employer______________________________________

Address____ Work Phone _________________________

Name of Spouse _________________________ Occupation ____________________________________

Spouse's Employer _____________________________________ Work Phone _________________________

Nearest Relative Name ___________________ Address ______________________________________

Insurance Company ______________________ Policy # __________________ Group # _______________

Referred by ________________________ Date of Last Physical Exam _________________________

Have you ever suffered from:

	Yes	No		Yes	No
1. Dizziness	___	___	8. Asthma	___	___
2. Backaches	___	___	9. Neuritis	___	___
3. Heart Trouble	___	___	10. Digestive Disorders	___	___
4. Diabetes	___	___	11. Nervousness	___	___
5. Tuberculosis	___	___	12. Sinus Trouble	___	___
6. Arthritis	___	___	13. Anemia	___	___
7. Headaches	___	___	14. Cancer	___	___

Purpose of this appointment____

Other doctors seen for this condition ____

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.

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and me. Furthermore, I understand that Fratto Hopstock Chiropractic, Inc. 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 Fratto Hopstock Chiropractic, Inc 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. I hereby request and consent to chiropractic adjustments and other chiropractic procedures, including various forms of physiotherapy and diagnostic x-rays as deemed necessary by the doctors of Fratto Hopstock Chiropractic, Inc.

Patient's Signature ______________________________________ Date ______________________

Guardian or Spouse Signature _______________________________ Date ______________________

Information taken by _____________________________________ Date ______________________