CONFIDENTIAL PATIENT INFORMATION

Date___________________

Name_________________________________ Email:____________________________

Address____

City___________________Zip code_________

Home Phone_______________________ Cell_________________________

Age_____Birthdate_________Marital M S D W Children/ages?_________________

Occupation_____________________ Employer_________________________

Employer address_________________________________City____________________

Employer phone_________________________

Name of spouse________________________________

Spouse's employer and phone_________________________________

Patient's nearest relative____________________________Phone____________________

Were you referred? By whom?_________________________________

Date of last physical____________________

What operations have you had?____

Serious illnesses____

Are you taking prescription or over the counter medications? Please list and why taking

____

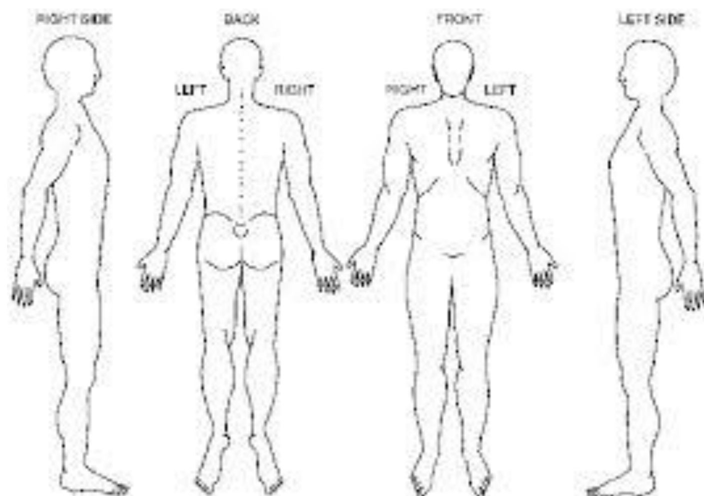
Do you suffer from:

Dizziness______	Headache_______	Digestive problems_______
Backache_______	Heart trouble______	Nervousness________
Shoulder pain_____R___L___	Diabetes________	Sinus problem________
Foot pain_____R___L___	Arthritis_____	History of cancer_______
Knee pain____R___L___	Asthma______	
Low back pain____	Neck pain______	

Purpose of this appointment____

Is this visit due to a car, work, or other accident? ___________When? ______________

Indicate where you have pain or other symptoms on the drawing below:



How often do you experience your symptoms?

___ Constantly (76-100% of the day)

___ Frequently (51-75% of the day)

___ Occasionally (26-50% of the day)

___ Intermittently (0-25% of the day)

What describes the nature of your symptoms?

___ Sharp ___ Shooting

___ Dull Ache ___ Burning

___ Numb ___ Tingling

How are your symptoms changing?

___Getting Better ___Not Changing ___Getting Worse

On a scale of 0-10 with 0 being No intensity and 10 being Unbearable, rate the average intensity of your symptoms: 0 1 2 3 4 5 6 7 8 9 10

PAYMENT IS EXPECTED AT TIME OF VISIT

WHO IS RESPONSIBLE FOR PAYMENT?________________________
Name of insurance company______________________________
Policyholder___________________________
Insurance ID_________________________Group#____________________
Policyholder birthdate__________________
Policyholder SS#__________________________

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and me. Furthermore, I understand that Rasper Chiropractic 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 Rasper Chiropractic 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 to me will be immediately due and payable. I further agree that should suit be brought to collect outstanding charges, I will pay all collection costs, including attorney fees and court costs incurred by Rasper Chiropractic.

I consent to any exam and treatment deemed necessary by the attending physician or nurse or qualified designate.

I also consent to the examination and treatment of my child if he or she is the patient.
In case x-rays are necessary, are you pregnant? Yes____No_____N/a____

Date________________
Patient's
signature_______________________________SS#___________________________

Guardian or spouse's signature authorizing
care______________________________________