DERBY CHIROPRACTIC

CONFIDENTIAL

Patient #:

CONFIDENTIAL PATIENT INFORMATION

DATE: _____

Name _____ Social Security: ☐☐☐ ☐☐ ☐☐☐☐
First Middle Initial Last

Address: _____ City _____ State _____ Zip _____

Home Phone: _____ Cell Phone: _____ E-Mail: _____

Age _____ Birth Date _____ / _____ / _____ Marital: M S W D Sex: M F How Many Children? _____

Occupation _____ Employer _____ Phone_____

Employer Address _____ City _____ State _____ Zip _____

Name of Husband or Wife _____ Employer _____

Employer Address _____ City _____ State _____ Zip _____

Name of Nearest Relative _____ City _____ State _____ Phone _____

I was referred here by:_____ I got your phone number in: ☐ Feist ☐ SWBYP's ☐ Tri-Cities

Is the condition due to injury or sickness arising out of employment? ☐ Yes ☐ No

Is the condition due to injury or sickness arising out of auto or other accident? ☐ Yes ☐ No

Days lost from work? _____ Date symptoms appeared or accident happened _____

Have you ever had the same or similar condition: ☐ Yes ☐ No If Yes, when & describe: _____

Purpose of this appointment_____

Other doctors seen for this condition_____ When_____

Have you been treated for any health condition by a physician in the last year? ☐ Yes ☐ No

Describe _____

What medications or drugs are you currently taking? _____

Please indicate the type of care you are desiring: ☐ Symptom Relief Only ☐ Correction of the Problem ☐ Both

Would you like advice or recommendations on how to avoid a relapse of this conditon in the future: ☐ Yes ☐ No

Health Insurance Company: _____

(If MEDICARE, Please Provide ID #: _____ and any Supplemental Insurance Info Below):

POLICY #: _____ Group #: _____

INSURED's Full Legal Name_____

INSURED's SS#: ☐☐☐ ☐☐ ☐☐☐☐ **Insured's** Date of Birth: _____ / _____ / _____

INSURED's Place of Employment_____

2nd Insurance Co: _____ 2nd Insured's Name: _____

2nd Insurance Employer: _____ Birthdate: _____ / _____ / _____ SS#: _____

I understand that I am ultimately responsible for payment in full at this office.
I understand that health and accident insurance policies are an arrangement between my insurance company and myself - not between my insurance company and this office.
I authorize direct payment of medical benefits to Derby Chiropractic, P.A. and release of medical information necessary to process my insurance claims.

Patient Signature _____ Date_____

Individual responsible for bill (if different from patient)_____

Patient Name_______________________________

Date	Additional Comments: