

# LANCASTER CHIROPRACTIC REHAB CENTER

Social Security # \_\_\_\_\_

## CONFIDENTIAL PATIENT INFORMATION

E-Mail Address \_\_\_\_\_

Legal Name \_\_\_\_\_ Home Phone \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Age \_\_\_\_\_ Birth Date \_\_\_\_\_ Marital Status: M S W D How many Children? \_\_\_\_\_

Occupation \_\_\_\_\_ Employer \_\_\_\_\_ Work Phone \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Name of Wife or Husband \_\_\_\_\_ Birth Date \_\_\_\_\_ Occupation \_\_\_\_\_

Employer \_\_\_\_\_ Family Doctor \_\_\_\_\_ May We Contact? \_\_\_\_\_ Yes \_\_\_\_\_ No

Patient's Nearest Relative \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Referred By \_\_\_\_\_ Date of Last Physical Examination \_\_\_\_\_

### 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. AIDS or HIV+	_____	_____
5. Stroke	_____	_____	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

Name of Person Responsible for Payment: \_\_\_\_\_

Are You Insured? YES NO Company: \_\_\_\_\_ Group No. \_\_\_\_\_

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that the Lancaster Chiropractic Rehab Center will prepare any necessary forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to the Lancaster Chiropractic Rehab Center 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 understand that no guarantee has been made as to the results of treatment and I understand that if I suspend or terminate my care and treatment, any fees for professional services rendered will be immediately due and payable. No charge for consultation; does not include exam, x-rays, treatment or any other services. I acknowledge & understand that I have the option of having a third party present during the initial exam. I hereby give my consent to receive e-mail newsletters from this office. By signing this Confidential Patient Information sheet, I acknowledge I received a copy of same.

Patient's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Guardian or Spouse's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Information Taken By: \_\_\_\_\_ Date: \_\_\_\_\_

IF YOURS IS AN ACCIDENTAL INJURY, PLEASE ADVISE RECEPTIONIST.