Date_____

CONFIDENTIAL PATIENT INFORMATION

Name_____ Phone (h) _____ (c) _____

Address_____City_____Zip_____

Age_____ Birth Date_____/_____/_____ E-mail_____

Occupation_____Employer_____

Address_____Work Phone_____

Marital Status ☐ Single ☐ Married ☐ Widowed ☐ Divorced

Spouse/Partner Name_____ Occupation_____

Who should we contact in case of emergency _____Phone _____

Referred by:_____

Date of last physical examination_____ Referred by_____

HAVE YOU EVER SUFFERED FROM:	YES	NO		YES	NO
Dizziness	☐	☐	Asthma	☐	☐
Backaches	☐	☐	Neuritis	☐	☐
Heart Troubles	☐	☐	Digestive Disorders	☐	☐
Diabetes	☐	☐	Nervousness	☐	☐
Tuberculosis	☐	☐	Sinus Trouble	☐	☐
Arthritis	☐	☐	Anemia	☐	☐
Headaches	☐	☐	Cancer	☐	☐

Reason for today's 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/ additional information_____

PAYMENT IS EXPECTED AT THE TIME OF VISIT. Will you be paying by ☐ Cash ☐Check ☐ Credit Card

Person responsible for payment_____

Are you insured ☐ Yes ☐ No

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that CARBONELL CHIROPRACTIC HEALTH CENTER will prepare all necessary reports and forms to assist me in making collection from the insurance company and that any amounts authorized are to be paid directly to CARBONELL CHIROPRACTIC HEALTH CENTER and will be credited to my account. However, I clearly understand and agree that any services rendered 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 all fees for professional services rendered me will be immediately due and payable.

PATIENT SIGNATURE_____DATE_____

GUARDIAN SIGNATURE_____DATE_____