----------SWEETWATER CHIROPRACTIC----------
CONFIDENTIAL PATIENT INFORMATION

How were you referred to this clinic? _____

PATIENT DATA

Name_____ Age _____ DOB _____

Address _____ City _____State_____ Zip_____

Home Phone _____ Work Phone _____Cell Phone _____

SS # _____ Occupation_____ Employer_____

Marital Status_____ Spouse's Name_____ Employer_____

Emergency Contact _____Phone _____

Patient's E-Mail Address _____

PRESENT COMPLAINT

Are your symptoms related to an accident? □ Yes □ No

Briefly Describe Symptoms _____

_____

List other Doctors seen for this Condition _____

MEDICAL HISTORY (Please check any of the following symptoms, if relevant to your medical history)

□ Anemia	□ Arthritis	□ Asthma
□ Back Pain	□ Cancer	□ Concussion
□ Convulsions	□ Diabetes	□ Digestive Disorders
□ Dizziness	□ Epilepsy	□ Heart Disease
□ Hepatitis	□ Hypertension	□ Multiple Sclerosis
□ Nervousness	□ Numbness	□ Polio
□ Rheumatoid Arthritis	□ Sinus Trouble	□ Urinary Infections

Other: _____

Have you received medical treatment for any condition in the last year? □ Yes □ No

Describe: _____

Describe what operations you have had: _____When? _____

Primary Care Physician _____Date of Last Physical Exam _____

Are you taking any regular medication? □ Yes □ No What Kind? _____

Are you pregnant? □ Yes □ No Date of Last Menstrual Period _____

INSURACNE DATA

Name of Party Responsible for Payment _____Phone # _____

Do you have insurance? □ Yes □ No Company _____

Employee ID #_____ Policy # _____Group # _____

I understand and agree that my insurance policy is an agreement between the insurance company and myself. I understand that this office 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 this office will be credited to my account upon receipt. I permit this office to endorse co-issued remittances for the conveyance of credit to my account. 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.

Patient's Signature_____ DATE_____

Spouse's or Guardian's Signature _____DATE_____

SWEETWATER CHIROPRACTIC
ACCIDENTAL INJURYY

If your visit is related to an accident, please complete this page

DATE OF ACCIDENT _____ Time of Accident _____ AM PM

WORK RELATED ACCIDENT

Employer _____Type of Business _____

Was the accident reported to your Supervisor and/or Employer? □ YES □ NO

Has a Worker's Compensation claim been filed? □ YES □ NO

Briefly describe the accident _____

_____

_____

AUTOMOBILE ACCIDENT

Were you the □ Driver □ Passenger □ Pedestrian Were you wearing a seatbelt? □ YES □ NO

If a passenger, please indicate your location in the vehicle _____

Was your vehicle moving when the accident occurred? □ YES □ NO Estimated Speed? _____mph

Did your vehicle hit other vehicles? □ YES □ NO Where? _____

Did other vehicles hit your vehicle? □ YES □ NO Where? _____

Was the accident reported to the Police? □ YES □ NO _____

Were any traffic citations issued? □ YES □ NO To whom? _____

Briefly describe the circumstances of the accident _____

_____

_____

Describe your symptoms _____

_____

Did you go to the hospital following the accident? □ YES □ NO Where? _____

Have you seen any other doctor's for this condition? □ YES □ NO Who? _____

Have you had similar symptoms in the past? □ YES □ NO

Any other health related issues? _____

INSURANCE COMPANIES

Insurance company or name of party responsible for payment _____ Claim # _____

Have you been contacted by an insurance company adjuster or company representative about your claim? □ YES □ NO

Do you have an Attorney in this case? □ YES □ NO If yes, Name & Address _____

_____

PATIENT'S SIGNATURE _____ DATE _____