Acct#: _____ (Office Use) Rev. 2/7/2020

Confidential Patient Information **Email:**_____

(This form is to be completed by the Patient / Examinee – Please print!) **SocSec#:**_____-_____-_____

Legal Name: _____ **Age**:____ **Date of Birth**:___/___/___ **Sex:** M__ F__

Address:_____ **City** _____ **State** _____ **Zip** _____

Home Phone#: (_____) _____ **Cell: (_____)** _____

Emergency Contact: _____ **Phone#: (_____)** _____

What is your preferred method of contact? (Check one): Home Phone____ Cell_____ E-mail____ Postal Address_____

Marital Status: M S W D Do you have any children? Y or N If yes, how many do you have? _____

Your Occupation? _____ **How many years?** _____

Your Employer: _____ **Phone#: (_____)** _____

Employer Address:_____ **City** _____ **State** _____ **Zip** _____

Spouse Name _____ **Spouse Date of Birth**:___/___/___

Spouse Phone#: (_____) _____**Spouse Occupation?** _____

Spouses Employer: _____ **Phone#: (_____)** _____

Purpose for this appointment: _____

Have you seen other Doctors for this condition? Y or N Doctor's Name: _____

Have you been treated for ANY health condition by a physician in the last year? YES NO

Describe: _____

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 my exam(s). 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.

I hereby authorize the doctor to release all my medical information necessary to process my claims. I also authorize any plan administrator or fiduciary, insurer and my attorney to release to such doctor and clinic any and all plan documents, insurance policies, Summary Plan Description and/or settlement information upon written request from such doctor and clinic in order to claim such medical benefits, reimbursement or any applicable remedies. I hereby authorize the doctor to release any and all medical information to other healthcare providers involved in my care including but not limited to my primary care physician. I authorize the use of this signature on all my insurance and/or employee health benefits claim submissions.

Patient's Signature: _____ **Date:** _____

Guardian or Spouse's Signature: _____ **Date:** _____

Information Taken By: _____ **Date:** _____

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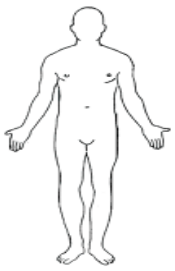
Legal Name:_____ **Date of Birth**:___/___/____ **Today's Date:**___/___/____

Vitals: Height:_____ Inches Weight: ____ Lbs. Blood Pressure (Estimate) ____/_____ Pulse _____

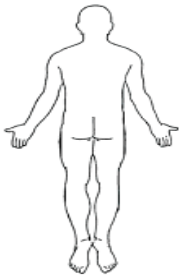
What is your Shoe Size? _____ " Width (Narrow) A__B__C__D__E__ (Wide)

Have You Ever Suffered From:	**YES or NO**		**(Must answer "Yes" or "No" for each box)**	**YES or 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**	☐ ☐

Front



Back



Using the SYMBOLS below; mark the area(s) of the body (See Left) where you feel the following sensations:

+	**Numbness**
*****	**Burning**
o	**Pins and Needles**
□	**Sharp**
X	**Dull and Aching**

Your Family Doctor: _____ **Phone#: (____)** _____

Date of your last Physical Examination: _____/_____/_____ **May we contact them? Yes or No**

What is your Ethnicity – Hispanic or Latino? Y or N What is your Race? _____

Whom may we thank for referring you to this office? _____

Please list your prescriptive medications:

	Brand Name	Generic Name	Strength (I.e.10mg)
1.	_____	/ _____	/ _____
2.	_____	/ _____	/ _____
3.	_____	/ _____	/ _____
4.	_____	/ _____	/ _____
5.	_____	/ _____	/ _____
6.	_____	/ _____	/ _____

Please list any medications that you are allergic to:

1. _____ 2._____ 3._____

Hospitalizations: Please state the year, the illness & the operation. (This does not include normal pregnancies).

Year	Illness/Operation	Year	Illness/Operation

Patient's Signature: _____ **Date:** _____