UOV TUOAR Today's Date: ____/ File #:___ Patient Name: _____ FIRST INSURANCE INFO What You Prefer To Be Called: ☐ Male ☐ Female Primary Insurance Birthdate: / / Age: SS#: Co. Name: Mailing Address:___ Address: STATE Home Phone #:_____ CITY STATE Phone #: Work Phone #: _____ Ext:____ Insured's SS#: Other Phone #s: Group # (Plan, Local, or Policy #):____ E-mail Address: Insured's Name: ___ Referred By: ____ How Long?___ Employer: ______ Date of Birth: __/__/ Relation:___ Employer's Address:_____ Insured's Employer:__ Secondary Insurance CITY STATE Co. Name: Address: Status: ☐ Minor ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed Spouse's Name: CITY STATE Do you have children? ☐ Yes ☐ No How many? Phone #: Insured's SS#: Group # (Plan, Local, or Policy #):____ A((OUNT INFO Insured's Name:____ Relation:____ ___Date of Birth: ___/__/ Person ultimately responsible for account Insured's Employer: _ Name: Relation: Billing Address:____ IN EAEML OL EWEBCENCA CITY STATE SS #: _____ Who should we contact? Drivers License #: Relation: Work Phone #:_ Home Phone #: Work Phone #: ☐ Credit Card - Enter card # above (if accepted) Who is your Medical Doctor?____ M.D.'s Phone #: I hereby authorize assignment of my insurance Initials rights and benefits directly to the provider for services rendered. I fully understand I am solely responsible for any balance not paid by my insurance company (if offered at this office).

MEN	REASON	1514 401
5	Reason for today's visit: Emergency New injury Old injury Chronic pain We	ellness
	Are you in pain: Yes No Rate your pain with the following scale: discomfort 1 2 3 4 5 6 Did your injury occur during: Work Sports/play Auto Accident Routine/Househo	7 8 9 10 intense
	When did your condition/accident occur?// Where did your injury occur?	old activity
	Please explain what happened:	
	Is your condition getting worse? Yes No Constant Comes and goes.	
$M\Lambda$	Is your condition interfering with your: Work Sleep or Daily routine? If so, how:	7
Will	Has this or something similar happened in the past?	0
	☐ Yes ☐ No Explain:	£°(
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	Using the adjacent body charts, please circle	(t) 1 1.
	Have you been treated by a Medical Physician for this	
the second	condition? ☐Yes ☐No If so, where?	/ wi w
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	Have you ever been treated by a Chiropractor? ☐Yes ☐No Clinic or Dr's name:	
\$\$\$\$	Clinic phone#:	21
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