

**PREMIER CHIROPRACTIC CENTER
CONFIDENTIAL PATIENT INFORMATION**

Name: _____ Date: _____

Address: _____

Zip Code: _____ City: _____ State: _____

Home Phone: _____ Cell Phone: _____ Work: _____ Ext: _____

Age: ____ Birth Date: _____ Social Security #: _____

Sex: Male ____ Female ____ Marital: M S W D How Many Children? _____

Occupation: _____ Employer: _____

Work Address: _____ City: _____ State: ____ Zip: _____

Name of Spouse: _____ Spouse's Employer: _____

Patient's Nearest Relative: _____ Address: _____

Date of Last Physical Exam: Medical _____ Chiropractic: _____

Operations Have You Had? _____

When? _____

Referred By: _____

Have You Ever Suffered From: (Please Place an "X" in the spaces provided)

Dizziness _____	Backaches _____	Heart Trouble _____	Diabetes _____
Tuberculosis _____	Arthritis _____	Asthma _____	Numbness _____
Headaches _____	Neuritis _____	Digestive Disorders _____	Nervousness _____
Cancer _____	Anemia _____	Rheumatic Fever _____	Sinus Trouble _____

Purpose of this Appointment: _____

Other Doctors Seen for this Condition: _____

Is Your Illness/Injury Work Related: Yes No Auto Accident: Yes No

Has a Physician treated you for any health condition in the last year? Yes No

Describe: _____

What medications are you taking?: _____

Remarks or Additional Information: _____

AUTHORIZATION TO RELEASE INFORMATION: I/We hereby authorize Premier Chiropractic Center, Ltd. to release any medical or incidental information that may be necessary for medical benefit or in processing applications for financial benefit. This includes but is not limited to my insurance company, Rehabilitation Services, Social Security Administration and Worker's Compensation.

CONSENT FOR TREATMENT: I/We hereby authorize Premier Chiropractic Center, Ltd. to administer diagnostic and medical procedures as may be necessary for proper health care.

OFFICE POLICY ON PAYMENT: I understand that I am responsible for payment of all charges. As a courtesy, my insurance will be billed for me. It is my responsibility to pay any deductible, copay or any other balance not paid for by my insurance company. I authorize insurance benefits to be paid directly to the provider.

SIGNATURE: _____

DATE: _____

Patient (over 18 years) or responsible party

