CONFIDENTIAL PATIENT INFORMATION

Name_____ Social security #: _____

Address_____City_____State_____ZipCode_____

Home Phone:_____ Cell Phone: _____

Email address: _____ (For special programs and newsletters)

Age_____Birth Date_____/_____/_____Marital Status: M S W D How many Children? _____

Occupation_____ Employer _____

Address_____ Office Phone _____

InsuranceCompany_____ Policyholder's Name_____ Birth Date____/____/____

Name of Husband or Wife_____ Occupation _____

Patient's nearest Relative (if not married) _____

Address_____

Referred by: _____ Primary Physician: _____

Primary Clinic: _____ Date of Last Exam:_____

Have you ever suffered from:	YES	NO		YES	NO
1. Dizziness	☐	☐	8. Asthma	☐	☐
2. Backaches	☐	☐	9. Neuritis	☐	☐
3. Heart Trouble	☐	☐	10. Digestive Disorders	☐	☐
4. Diabetes	☐	☐	11. Nervousness	☐	☐
5. Tuberculosis	☐	☐	12. Sinus Trouble	☐	☐
6. Arthritis	☐	☐	13. Anemia	☐	☐
7. Headaches	☐	☐	14. Cancer	☐	☐

Purpose of this 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: _____
_____

PAYMENT IS EXPECTED AT THE TIME OF VISIT!
Name of Person Responsible for Payment: _____
Are you Insured? ☐ YES ☐ NO

I understand and agree that health and accidental insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that Petterson Chiropractic Clinic 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 Petterson Chiropractic Clinic 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 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. A finance charge of 18% annually (1.5% per month) will begin accruing after 60 days from the date of service.

Patient's Signature: _____ Date: _____

Parent or Guardian's Signature: _____ Date: _____

Approved by Professional Chiropractic Society of America (PCSA)