



COLLIN | CHIROPRACTIC

Today's date:		PCP:				
PATIENT INFORMATION						
Patient's last name:		First:	Middle:	<input type="checkbox"/> Mr. <input type="checkbox"/> Mrs.	<input type="checkbox"/> Miss <input type="checkbox"/> Ms.	Marital status (circle one) Single / Mar / Div / Sep / Wid
Preferred name? <input type="checkbox"/> Yes <input type="checkbox"/> No	What is your preferred name?		Birth date: / /		Age:	Sex: <input type="checkbox"/> M <input type="checkbox"/> F
Street address:			Social Security Number:		Home/Cell Phone Number: ()	
City:		State:		Zip Code:		EMAIL:
Occupation:		Employer:			Employer Phone Number: ()	
Referred to clinic by (please check one box):						<input type="checkbox"/> Dr. <input type="checkbox"/> Insurance Plan <input type="checkbox"/> Gym
<input type="checkbox"/> Family		<input type="checkbox"/> Friend		<input type="checkbox"/> Promo Event		<input type="checkbox"/> Online/Website <input type="checkbox"/> Other
Other family members seen here:						

INSURANCE INFORMATION						
(Please give your insurance card to the receptionist.)						
Person responsible for bill:		Birth date: / /	Address (if different):		Home phone no.: ()	
Is this person a patient here? <input type="checkbox"/> Yes <input type="checkbox"/> No						
Occupation:	Employer:	Employer address:			Employer phone no.: ()	
Is this patient covered by insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No						
Subscriber's name:		Subscriber's S.S. no.:	Birth date: / /	Group no.:	Policy no.:	Co-payment: \$
Patient's relationship to subscriber: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other						
Name of secondary insurance (if applicable):		Subscriber's name:		Group no.:	Policy no.:	
Patient's relationship to subscriber: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other						

IN CASE OF EMERGENCY					
Name of local friend or relative (not living at same address):			Relationship to patient:	Home phone no.: ()	Work phone no.: ()
The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Collin Chiropractic or insurance company to release any information required to process my claims.					
_____ <i>Patient/Guardian signature</i>				_____ <i>Date</i>	

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HEALTH HISTORY QUESTIONNAIRE

All questions contained in this questionnaire are strictly confidential and will become part of your medical record.

Name <i>(Last, First, M.I.):</i>	<input type="checkbox"/> M <input type="checkbox"/> F	DOB:
Marital status: <input type="checkbox"/> Single <input type="checkbox"/> Partnered <input type="checkbox"/> Married <input type="checkbox"/> Separated <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed		
Previous or referring doctor:	Date of last physical exam:	

PERSONAL HEALTH HISTORY

List any medical problems that other doctors have diagnosed

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Surgeries

Year	Reason	Hospital

Other hospitalizations

Year	Reason	Hospital

List your prescribed drugs and over-the-counter drugs, such as vitamins and inhalers

Name the Drug	Strength	Frequency Taken

