Green Chiropractic Office
Patient Intake Form

Name ______________________________________ Male __ Female __ Single __ Married __ Widowed __ Divorced __

How you prefer to be addressed _______________________ Birthdate ______/______/______ Age__________

Social Security # _______-_______- _________ Drivers License # _________________________ State _______

Street Address ____ Home Phone ____-____-_____

City ____ State ____________ Zip Code __________- __________

Employer's Name ____ What do you do there? _________________________

Employer's Address ____ Years with present employer _________________

Work Phone # _____-_____- ________ Ext. # _________ Okay to call you at work? Yes No

Referred to our office by ____

In Case of Emergency Contact ____________________________ Phone # ____-_____-______ Relationship _____________

INSURANCE INFORMATION

Is your current condition the result of an accident/injury? Yes __ No ___ If yes: Auto __ Work __ Slip/Fall __

Primary Insurance Company

Ins. Co. Name _____________________________________ Group # (Plan, Local or Policy #) _________________________

Address _____________________________________ Insured's Name ____

_____________________________________ Relation _____________________ Birthdate _____________

Ins. Co. Phone # ____________________ Insured's Social Security # ___________________________

Insured' s Employer ________________________________ Address ____

Secondary Insurance Company

Ins. Co. Name _____________________________________ Group # (Plan, Local or Policy #) ________________________

Address _____________________________________ Insured's Name _______________________________________

_____________________________________ Relation ____________________ Birthdate ____________

Ins. Co. Phone # ____________________ Insured's Social Security # __________________________

Insured's Employer __________________________________ Address ____

HEALTH HISTORY

List Any Allergies You May Have ____

____

List Any Prescription/Non-prescription Medications You Are Taking ____

____

List Any Non-prescription / Over the Counter Medications You Are Taking _____________________________________

____

List Previous Surgeries With Dates ____

____

List Any Serious Accidents / Injuries With Dates ____

____

<u>FOR WOMEN ONLY</u>

Are You Taking Birth Control Pills? Yes ___ No ___

Are You Pregnant? Yes ___ No ___ If Yes, Expected Due Date _____________

Are You Currently Nursing? Yes ___ No ___

We invite you to discuss frankly with us any questions regarding our services. The best chiropractic care is based on a friendly, mutual understanding between doctor and patient.

Our Office Policy requires payment in full for all chiropractic services rendered at the time of visit, unless other arrangements have been made with our business office. For your convenience this office may submit insurance claim forms to your designated insurance company on an assigned basis. Any and all charges not paid by the insurance company are the responsibility of the patient. If the account is not paid within 90 days of receipt of the statement, the patient will be responsible for any expenses incurred in collecting your account.

I hereby authorize payment of benefits directly to doctor of benefits due me for services rendered. I further authorize doctor to release any information required to process insurance claims.

I understand the above information and guarantee this form was completed to the best of my knowledge. I understand it is my responsibility to inform this office of any changes in my health status.

Signature of Patient (Responsible Person) ____ **Date ____/_____/_____**