CONFIDENTIAL PATIENT INFORMATION

NAME: _____DATE: _____

ADDRESS:_____

CITY: _____STATE: _____ZIP: _____

HOME PHONE: _____ CELL : _____WORK: _____

DATE OF BIRTH _____ GENDER: ☐ MALE ☐ FEMALE SSN: _____

MARTIAL STATUS: ☐ SINGLE ☐ MARRIED ☐ DIVORCED ☐ WIDOWED ☐ SEPARATED

OCCUPATION: _____EMPLOYER: _____

EMPLOYER ADDRESS: _____

SPOUSE'S NAME: _____OCCUPATION: _____

SPOUSE'S EMPLOYER ADDRESS: _____

EMERGENCY CONTACT: _____RELATIONSHIP:_____

EMERGENCY CONTACT PHONE: _____ REFERRED TO OUR OFFICE BY: _____

HISTORY OF PRESENT ILLNESS

CURRENT COMPLAINTS: _____

DATE OF INJURY: _____ DATE SYMPTOMS APPEARED: _____ SYMPTOMS: ☐ Increasing ☐ Decreasing ☐ Same

HOW DID YOUR PROBLEMS BEGIN: _____

WHAT MAKES YOUR SYMPTOMS WORST:_____ BETTER: _____

WHAT PERCENT OF THE DAY ARE SYMPTOMS FELT? ☐ 0-25 ☐ 25-50 ☐ 50-75 ☐ 75-100

HAVE YOU EVER HAD THIS CONDITION BEFORE: _____ HAVE YOU SEEN ANOTHER PROVIDER FOR THIS: _____

MEDICAL HISTORY

PLEASE INDICATE IF YOU HAD OR PRESENTLY HAVE ANY OF THE FOLLOWING CONDITIONS:

☐ Alcohol Addiction	☐ Anxiety	☐ Asthma	☐ Cancer	☐ COPD
☐ Crohn's Disease	☐ Depression	☐ Diabetes	☐ Drug Addition	☐ GERD
☐ Heart Disease	☐ Hepatitis	☐ Herniated Disc	☐ High Blood Pressure	☐ High Cholesterol
☐ Liver Disease	☐ Osteoarthritis	☐ Osteoporosis	☐ Renal Disease	☐ Seizures
☐ Stroke	☐ Thyroid Disease		☐ Tumors, Growth	☐ Ulcers

☐ Other: _____

CURRENT MEDICATIONS: (Please include prescription and over the counter medications) NONE: _____

NAME: DOSAGE:

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

PLEASE LIST ANY KNOWN ALLERGIES: _____

FAMILY HEALTH HISTORY:

PLEASE INDICATE IF A MEMBER OF YOUR FAMILY HAD OR CURRENTLY HAS ANY OF THE FOLLOWING CONDITIONS:

High Blood Pressure ☐ High Cholesterol ☐ Heart Disease ☐ Stroke ☐ Diabetes ☐ Cancer ☐

SOCIAL HISTORY/ACTIVITES OF DAILY LIVING:

SLEEP: _____ HOURS/NIGHT AGE OF MATTRESS: _____ YEARS / BRAND: _____

PILLOW TYPE: ☐ Feather ☐ Fiber-Filled ☐ Cervical SLEEP POSITION: _____

ALCOHOL INTAKE: ____ glasses/day **COFFEE** INTAKE: ____ glasses/day **SODA** INTAKE: _____ glasses/day

SALT INTAKE: ☐ LIGHT ☐ MED ☐ HEAVY **SUGAR** INTAKE: ☐ LIGHT ☐ MED ☐ HEAVY **SMOKE**: ____packs/day

VITAMINS: _____

EXERCISE: TYPE: _____ HOURS/WEEK: _____

WATER INTAKE: ____ glasses/day **WALKING**: _____ miles/day

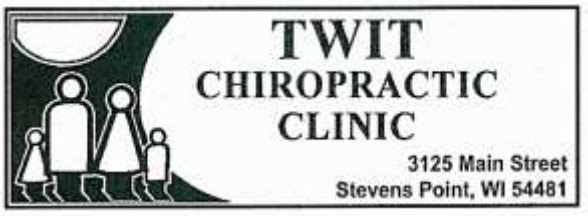
CURRENTLY USE: ☐ Heel Lifts ☐ Arch Supports ☐ Orthotics ☐ Back Supports

INSURANCE INFORMATION:

INSURANCE COMPANY: _____ POLICY NUMBER: _____GROUP: _____

POLICY HOLDER'S NAME: _____ POLICY HOLDER'S DATE OF BIRTH: _____

RELATIONSHIP TO PATIENT: _____



SIGNATURE / FINANCIAL AGREEMENT

Twit Chiropractic Clinic will submit claims to your insurance company and try our best to serve your needs as quickly, economically, and efficiently as possible. We will contact your insurance company to verify coverage; however this does not guarantee payment from your insurance company. You should receive the same information from the insurance company regarding your claims. By signing below you agree that the health and accident insurance policies are an arrangement between you and the insurance carrier. Furthermore, you understand that **Twit Chiropractic Clinic** will prepare necessary reports to assist in the collection from the insurance company and any amount authorized to be paid directly to **Twit Chiropractic Clinic** will be credited to your account. If you terminate your treatments, any fees for services rendered will be due immediately. I authorize the staff to perform any necessary services needed during treatment/diagnosis. I also authorize the provider to release any information required to process insurance claims. Please also note that any services not covered by insurance will be due immediately at the time of service.

It is our policy that we ask you for 20% payment on the day of service. Below are two options; please check and sign:

____ Yes, I wish to voluntarily pay 20% of my bill each visit, so my account balance does not get out of control

____No, I will pay each visit in full, once insurance has processed my claims.

I certify this information is true and correct to the best of my knowledge. I will notify **Twit Chiropractic Clinic** of any changes in my status or the above information.

PATIENT SIGNATURE: _____ DATE: _____

LEGAL GUARDIAN SIGNATURE: _____DATE: _____