VERNAL CHIROPRACTIC CLINIC'S
NEW CLIENT INFORMATION FORM

ABOUT YOU

Today's Date File #

Patient Name Last First Middle

What do you prefer to be called Sex

Birthdate Age SS#

Address City State Zip

Home Phone Work Phone Other Phone(s)

E-mail Address

Referred By

Employer How long

Employer Address City State Zip

Occupation Marital Status

Spouse's Name Do you have children How Many

INSURANCE INFO

Company Name Insured's Name

Insurance Company Address City State Zip

Phone Insured's ID# Group #

Relation Date Of Birth Insured's Employer

REASON FOR VISIT

The reason for your visit is a result of

Explain what happened

Please describe the pain and its location

When did the condition begin

Is the condition getting worse Is this condition interfering with your life

If so, please explain

Have you had similar conditions in the past

If so, please explain

Have you been treated by a Medical Physician for this condition

If so, where and when

Have you ever been treated by a Chiropractor before

If so, whom Phone Number

IN EVENT OF EMERGENCY

Who should we contact Relation

Home Phone Work Phone

Who is your Medical Doctor Phone

HEALTH HISTORY

Are you taking any of the following medications

Nerve Pills Pain Killers (Including Aspirin) Muscle Relaxers Stimulants

Blood Thinners Tranquilizers Insulin Other(s) Please list other(s) ______________________________

Do you have or have you ever had any of the following diseases or conditions

Heart Attack	Heart Surgery/Pacemaker	Heart Murmur
Congenital Heart Defect	Mitral Valve Prolapse	Artificial Valves
Alcohol/Drug Abuse	Venereal Disese	Hepatitis
HIV+/Aids	Shingles	Cancer
Frequent Neck Pain	Emphysema/Glaucoma	Anemia
High/Low Blood Pressure	Psychiatric Problems	Rheumatic Fever
Severe/Frequent Headaches	Kidney Problems	Ulcers/Colitis
Fainting/Seizures/Epilepsy	Sinus Problems	Asthma
Diabetes/Tuberculosis	Difficulty Breathing	Chemotherapy
Lower Back Problems	Artificial Bones/Joints	Arthritis

Please list any other serious medical condition(s) you have or have ever had

Please list anything that you may be allergic to

Please list **ANY** past serious accidents and dates

Family Health History

Do you take supplements or vitamins Do you excersise

Are you on a special diet If yes, since when

Do you smoke How much How long

Are you wearing What is the age of your mattress Is it comfortable

For Women: Are you taking birth control Are you pregnant If yes, how long Nursing

ACCOUNT INFO

Name of person ultimately responsible for account Relation

Billing Address City State Zip

SS# DL# Work Phone

Payment Method Enter Credit Card # (if accepted) Card expiration date (mm/yy) Card Code (3 digit code on back of card)

_______ I hereby authorize assignment of my insurance rights and benefits directly to the provider for services rendered. I fully understand I am solely responsible for any balance not paid by my insurance company (if offered at this office).

- We invite you to discuss with us any questions regarding our services. The best health services are based on a friendly, mutual understanding between provider and patient.
- Our policy requires payment in full for all services rendered at the time of visit, unless other arrangements have been made with the business manager. If account is not paid within 90 days of the date of service and no financial arrangements have been made, you will be responsible for legal fees, collection agency fees, and any other expenses incurred in collecting your account.
- I authorize the staff to perform any necessary services needed during diagnosis and treatment. I also authorize the provider and/ or managed care organization to release any information required to process insurance claims.
- I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes to the information I have provided.

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Signature Date