(__) CHIROPRACTIC (__) MEDICAL (__) REHAB (__) MASSAGE DR/RT/MT:_____

CONFIDENTIAL PATIENT FORM

Patient #: _____
Date: _____

PATIENT INFORMATION:

Name: _____ Phone: (___) _____

Address: _____ City: _____ State: _____ Zip: _____

Sex: ____ Marital Status: __S/M/D__ Date of Birth: ___/___/___ Social Security Number: _____

Name of Spouse or nearest relative: _____ Phone # (___) _____

Driver's License #: _____ Other ID: _____ E-mail address: _____

Occupation: _____ Employer: _____ Work Phone: (___) _____

Work Injury: Y / N Employer notified? Y/ N Name: _____

Please check the type of care desired: (__) Lasting Correction (__) Temporary Relief

How did you learn of this clinic? ___ Yellow pages /___ Spanish Yellow Pages/ ___ Newspaper/ ___ Web

___ Tele-marketing/ ___Sign/ ___ Insurance Company/ ___ Other: _____ Referred by: _____

AUTO ACCIDENT INFORMATION:

Date of Accident ____/____/____ Time of Accident _____ AM / PM # of people in vehicle _____

Details of Accident: _____

_____

_____

Do you have an attorney? Y / N Name: _____ Phone: _____

On Lien: Y /N Where you the: Driver ___ Passenger ___ Pedestrian ___ Did you hit the other vehicle: Y / N

Any tickets issued? Y / N If yes, to whom? _____

Any treatments since the accident? Y / N If yes, by whom? _____

Police Report Y/N Report #_____

PLEASE DO NOT WRITE BELOW THIS LINE, FOR OFFICE USE ONLY

INSURANCE INFORMATION	**ATTORNEY INFORMATION**	**3RD PARTY INFORMATION**
MedPay/Uninsured:_____	Name:_____	Insurance Name: _____
Claim#:_____	Address:_____	Claim #: _____
Name:_____	_____	Ins. Co.: _____
Address:_____	_____	Address: _____
_____	Phone:_____	_____
_____	Fax:_____	_____
Phone:_____	Notes:_____	Phone: _____
Fax:_____	_____	Fax:_____
Adjuster:_____	_____	Adjuster:_____
Chiro Y/N Limit: _____	Massage: Y/N Limit: _____	Rehab: _____
Accu: Y/N Limit: _____	Acceptance of Assignment of Benefits: Y/N	

Staff Completing Info: _____ Date: _____