



New Patient Information

Date _____

Name _____ Social Security No. _____

Home Address _____ City _____ State _____ Zip _____

Home Phone _____ Work Phone _____ Cell Phone _____

E-mail address _____

Employer _____ Position _____

Date of Birth _____ Age _____ Marital Status _____

Name of Spouse/Guardian _____ Referred by _____

Emergency Contact

Name _____ Address _____ Phone _____

What is your primary complaint? _____

Have you had this condition before? _____ If yes, when? _____

Date of injury/accident/illnesses _____ Location _____

How did it occur? _____ Auto collision _____ On the job _____ Other _____

Please describe the circumstances _____

Have you lost time from work? _____ If yes, give dates _____

What activities aggravate your condition? _____

Are you interested in symptomatic care or corrective care? _____

Do you regularly wear your seatbelt? _____ Do you regularly floss your teeth? _____

Have you had chiropractic care before? _____ If yes, where? _____

Past illnesses _____ When? _____

Operations (give location, date and reason for operation) _____

Are you presently under a doctor's care? _____ For what? _____

Current medications _____

Do you have any allergies? _____ If yes, please list _____

Females Only: Are you pregnant? _____ Number of children _____

Method of payment: _____ Cash _____ Check _____ Credit Card _____ Insurance

According to my insurance, I have a \$_____ copay at each visit.

PLEASE PRESENT YOUR INSURANCE CARD TO THE RECEPTIONIST

I understand and agree that health and accident insurance policies are an arrangement between the insurance carrier and I. Furthermore, I understand Corbett Chiropractic & Health Enhancement will prepare the necessary reports and forms to assist me in making collections from the insurance company and that any amount authorized to be paid directly to Corbett Chiropractic & Health Enhancement will be credited to this account upon receipt. However, I clearly understand and agree that all services rendered to me are charged directly to me and I am personally responsible for payment.

Signature of patient or guardian if patient is a minor

Date _____