NEW PATIENT INFORMATION

Welcome to our office! Please complete all fields below.

Name: ____ Date: ____________________________

Address/City/State/Zip: ____

Home Phone: ___________________ Work Phone: ___________________ Cell Phone: ___________________

Birth Date: ______________________ Age: ______ Social Security Number: ____________________________

Marital Status: ☐ M ☐ W ☐ D ☐ S ☐ O Email: ____

Your Employer: __________________________________ Occupation: ___________________________________

Spouse's Name: ______________________________ Spouse's Employer: ________________________________

Children's Names and Ages:

________________________________ _____ ________________________________ _____

________________________________ _____ ________________________________ _____

________________________________ _____ ________________________________ _____

Favorite Hobbies or Interests: ____

Method of Payment for First Visit: ☐ Cash ☐ Check ☐ Credit Card

Current health complaints / reasons for consulting our office:

1. ____
2. ____
3. ____
4. ____

Who may we thank for referring you? ____

Have you ever seen a chiropractor before? ☐ Yes ☐ No

If so, for how long? ____

Is this the result of an auto or work injury? ☐ Yes ☐ No If so, when? ____________________________________

Father, mother, brother, sister, children with similar problems? ☐ Yes ☐ No

If so, whom? ____

Other doctors you have seen for this problem: ____

Surgeries	Date
___________________________________	___________________
___________________________________	___________________
___________________________________	___________________

Medications you currently take:

Name	Dose	Frequency
_________________________	________________________	_________________________
_________________________	________________________	_________________________
_________________________	________________________	_________________________
_________________________	________________________	_________________________
_________________________	________________________	_________________________

Vitamins / Supplements: ____

Is there any chance that you are pregnant? ☐ Yes ☐ No

Have you ever been diagnosed with cancer? ☐ Yes ☐ No

If so, what kind? ____

Do you have health insurance? ☐ Yes ☐ No Name of company: _______________________________________

1. All first visit charges are payable when services are rendered.

2. The fee paid for treatment x-rays is for analysis only. The film itself is the property of this office. Once films are used for treatment purposes, they cannot be released.

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and me. Furthermore, I understand that Creedmoor Wellness Center will prepare any necessary reports and forms to assist me in making collections from the insurance company and that any amount authorized to be paid directly to Creedmoor Wellness Center will be credited to my account upon receipt. **<u>However</u>**, I clearly understand and agree that <u>I am personally responsible for payment</u>.

In case of emergency, please notify: ____

Name of nearest relative not living with you.

Relationship: _______________________________

Address: ____

Phone number: _(_____)___________________________

The above information is true and accurate to the best of my knowledge.

Patient or Guardian Signature: __________________________________ Date: _________________________

<u>Note:</u> Signatures on forms must be hand-signed on form that has been printed out. Thank you!