Patient Information Form

General Information

Patient's Name: Birthdate:

(Last) (First)

SSN: Martial Status: ☐ Never Married ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

Address:

(Street) (City) (State/Prov.) (Zip/P.C.)

Home Phone: ( ) Cell Phone: ( ) Work Phone: ( )

Email: Employer:

Emergency Contact: Phone: ( ) Relation:

Health History

Chief Complaint/Reason for Visit: How did you hear about us?:

History of Present Illness:

Location: Quality:

(Where is the pain/problem?) (Example: normal vs. abnormal color, activity, etc.)

Severity: Duration:

(How severe is the pain/problem on a scale from 1-10?) (How long have you had this pain/problem?)

Timing: Context:

(Does the pain/problem occur at a specific time?) (Where were you at the onset of this pain/problem?)

Associated signs/symptoms: Modifying factors:

(What other associated problems have you been having?) (What makes the pain/problem worse or better?)

Past Hospitalizations:

Previous Surgeries:

Any Medical Problems:

Do you have: ☐ High Blood Pressure ☐ Diabetes Are you currently pregnant? ☐ Yes ☐ No

Medications: (Include nonprescription)

Allergies:

Psychiatric History: ☐ Memory Loss or Confusion ☐ Anxiety/Nervousness ☐ Depression ☐ Insomnia ☐ Suicidal or Violent Thoughts

Use of Alcohol: ☐ Never ☐ Rarely ☐ Moderate ☐ Daily

Use of Tobacco: ☐ Never ☐ Previously, but Quit: ☐ Currently, Packs/day: .

Use of Drugs: ☐ Never ☐ Type/Frequency: .

•To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my health. It is my responsibility to inform Slayton Chiropractic Inc. of any changes in my medical status.

Signature: Date:

Financial

•I understand that I'm financially responsible for all charges for services to me,including the balance remaining after payment of possible insurance benefits.

Signature: Date:

•Assignment of Benefits:I authorize payment of medical benefits to myself, or names given, for professional services rendered by Slayton Chiropractic Inc.

Signature: Date:

•Release of Information: I authorize the release of any medical information necessary to process any and all claims.

Signature: Date: