UOV TUOGA / File #:__ Today's Date: ___ Patient Name: FIRST INSURANCE INFO What You Prefer To Be Called: ___ Primary Insurance Birthdate: / _/_ Age: SS#:___ Co. Name:___ Mailing Address:_____ Address: STATE CITY STATE Home Phone #:____ _____ Ext:___ Phone #:___ Work Phone #: Insured's SS#: Other Phone #s:___ Group # (Plan, Local, or Policy #):_____ E-mail Address: ___ Insured's Name: Referred By: __ Employer: How Long? Relation:_____ Date of Birth:__/_/ Employer's Address: Insured's Employer:___ Secondary Insurance STATE Co. Name:____ Occupation: Address: Status: ☐ Minor ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed Spouse's Name: __ STATE CITY Do you have children? ☐ Yes ☐ No How many? Phone #:_____ Insured's SS#: Group # (Plan, Local, or Policy #):_____ Insured's Name:_____ DINI INDO)) A Relation: __ Date of Birth: ___/ Person ultimately responsible for account Insured's Employer: Name: Relation: Billing Address: ____ IN EATHI OT EWEBCENCA CITY STATE SS #: _____

Control of the land of the party of the party of

Drivers License #:____

Signature

Work Phone #: __

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).

M.D.'s Phone #:

PLEASE CONTINUE ON BACK

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	Reason for today's visit: Emergency New injury Old injury Chronic pain V Are you in pain: Yes No Rate your pain with the following scale: According to the following scale: Acco	7 A 9 10 mense
16	Please explain what happened:	
	Is your condition getting worse? Yes No Constant Comes and goes.	
	Is your condition interfering with your: ☐ Work ☐ Sleep or ☐ Daily routine? If so, how:	
1	Has this or something similar happened in the past?	
1	☐ Yes ☐ No Explain:	Y 2.
	Using the adjacent body charts, please circle all affected areas. Have you been treated by a Medical Physician for this	
1	condition? QYes QNo If so, where?	1 198
Section 2	Have you ever been treated by a Chiropractor? QYes QNo	right
(3)4	Clinic or Dr's name:	11
	Clinic phone#: Right Front Back	Left
C	HEALTH 1	IISTORV
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