Patient Introduction Card

Patient Name: ____ Email: ___________________________________

Address: _____________________________________ City: ___________________ State: _________ Zip: ___________

Phone: (_____)__________________ Cell: (_____)_______________ Date of Birth: _____ / _____ / _____ Age: _________

□ Single □ Married; Name of Spouse: ______________________ Preference to be contacted: cell / home / email

Name of Children *(if applies)*: ______________________________ Name of Patient's Guardian *(if applies)*:______________________

Type of work/Occupation: _____________________________________ Work Phone: (_______)__________________

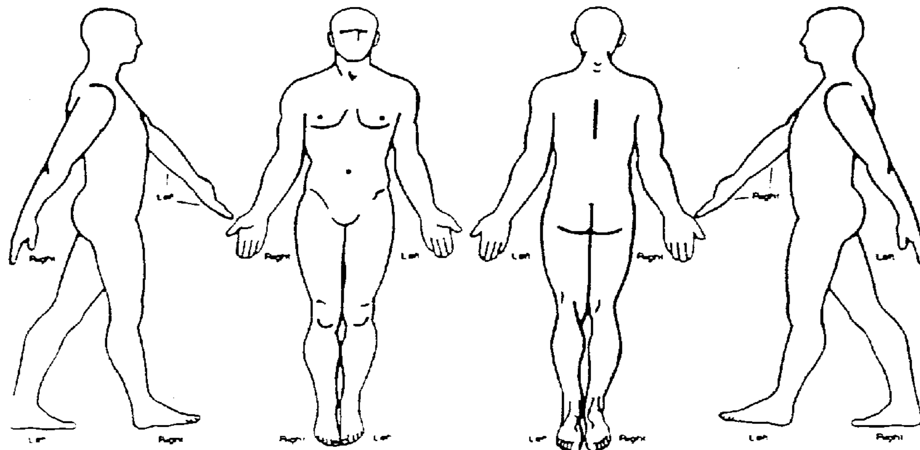
Insurance Company: ___________________ Insurance ID #:________________________ *(Please give our Front Desk your insurance card.)*

Insurance Policy Holder Name:__________________________________ Policy Holder's Date of Birth: _____ / _____ / _____

Your Primary Care Doctor? _____________________________ Phone: (______)______________________(Please initial) ___

Referred by: ___________________________________ Have you had chiropractic care before? _____ Yes _____ No

Outline area(s) where you have pain or other symptoms:



Please **circle** areas of pain and indicate what you have been feeling by using:

P (dull/ache pain)

S (sharp/stabbing pain)

B (burning pain)

N (numbness)

T (tingling)

Name areas of complaint: ____

____

Do you currently smoke: ___ Yes ___ No Did you ever smoke: ___ Yes ___ No Height: ________ Weight: _________

Are you allergic to any medications: ___ No ___ Yes; Please list them: ____

____

I certify this information to be true and accurate and I will notify you of any changes in my (or my child's) health status or any of the above. I also authorize the release of any medical or other information necessary to process insurance claims. I authorize and request the insurance company to pay directly to the clinic the insurance benefits otherwise payable to me. I understand that my insurance carrier may pay less than the actual bill for services. I understand that, regardless of the insurance status, I am always responsible for the charges for services rendered to me (or my child) at this clinic. There is a $25.00 missed appointment fee if you did not give us 24 hours notice for canceling chiropractic appointments. I certify that I received a Notice of Chiropractic & Family Wellness PC Privacy Practices. ______ (Please initial)

☐ - I hereby affirm that I am the **parent** or **guardian**, who is legally allowed to make medical decisions on behalf of this minor. I hereby authorize this office and its Doctor(s) to administer care as they so deem necessary to my Son/Daughter/Ward.

Signature of **Patient** (or Guardian): ____ Date: ______________________