CONFIDENTIAL PATIENT INFORMATION

Back to Essentials
A Complete Health and Wellness Center

Date_____

PLEASE PRINT and fill in EVERY blank. **Patient #**_____

Name (Full Legal) _____ SSN# _____

Address _____ City _____ State _____ Zip Code _____

Phone #: Home _____ Cell _____ Email: _____

Age _____ Birth Date _____ Sex: ☐M ☐F Marital Status: ☐M ☐S ☐W ☐D

Height _____ Weight _____ Native Language _____ Handedness: ☐R ☐L ☐A

Race: ☐Black ☐White ☐Hispanic ☐Asian ☐Other How Many Children? _____

Highest Level Completed: ☐Grade School ☐High School ☐College ☐Post Grad ☐Professional

Occupation _____ Employer _____

Employer Address _____ Employer Phone # _____

Guardian/Spouse's Name _____ SSN# _____

Birth Date _____ Occupation _____ Employer _____

Employer Address _____ Employer Phone # _____

Emergency Contact _____ Relationship _____ Phone# _____

Referred by (doctor, attorney, friend, or relative): _____Purpose of this Appointment _____

Date symptoms appeared/accident happened _____ It started: ☐Suddenly ☐Gradually Frequency _____

Is condition due to injury/sickness arising out of employment? ☐Yes ☐No Lost any days from work? ☐Yes _____ ☐No

Is the condition getting progressively worse? ☐Yes ☐No What makes it better/worse? _____

Is this condition interfering with your: ☐Work ☐Sleep ☐Daily Routine ☐Other: _____

Have you seen other doctors for this condition? ☐Yes ☐No Who? _____

Have you ever had same/similar condition? ☐Yes ☐No If so, when and describe? _____

Date of last physical exam: _____ Are you pregnant? ☐Yes ☐No Any serious illnesses? ☐Yes ☐No

What operations have you had? _____ Any broken/fractured bones? ☐Yes ☐No

Have you been treated for any health conditions by a physician in the last year? ☐Yes ☐No

If so, describe: _____

What medications or drugs are you taking? _____

Have you ever been under Chiropractic Care? ☐Yes ☐No Name _____

Do you take vitamins/minerals? ☐Yes ☐No Do you think you need vitamins/minerals? ☐Yes ☐No

Are you wearing: ☐Heel Lifts ☐Sole Lifts ☐Inner Soles ☐Arch Supports

PAYMENT IS EXPECTED AT THE TIME OF VISIT!

Name of person responsible for payment: _____

Payment: ☐Cash ☐Check ☐Visa ☐Master Charge ☐Health Ins. ☐Worker's Comp ☐Auto Med Pay

Attorney Information

Attorney's Name _____ Phone# _____

Address _____ City _____ State _____ Zip _____

Health Insurance

Insured's Name _____ Employer _____

Insurance Co _____ Policy/Member ID# _____

JOB INJURY INFORMATION

Date _____ Time _____ Injury reported to Employer? ☐Yes ☐No

Description of Accident: _____

_____

Name of Worker's Comp: _____

Address of Insurance Co.: _____

I understand and agree that health and accident insurance policies are an arrangement between me and an insurance carrier. Furthermore, I understand that this chiropractic office 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 this chiropractic office will be credited to my account on receipt. However, I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered me will be immediately due and payable.

Consent for Chiropractic Care

Chiropractic care is based on clinical evidence of vertebral subluxations and not the presence or absence of pain, abnormal range of motion, or abnormal spinal curves. By the use of specific analysis and spinal adjustments, the goal of chiropractic is to reduce/correct spinal subluxations.

- I understand that my records are the property of Back To Essentials, LLC. If at anytime I request a copy of my records there will be an additional charge for copying them.
- I authorize Back To Essentials, LLC to administer care as needed, as indicated from examination findings.
- I authorize Back To Essentials, LLC to release information to my doctor and/or insurance company.
- I understand that a condition of acceptance for care at Back To Essentials, LLC is that I not be under the care of any other chiropractor at the same time.
- A parent MUST accompany their minor child on every visit to Back To Essentials, LLC.

I have read and understand the above.

Patient's Signature _____ Date _____

Guardian/Spouse's Signature _____ Date _____

Information Taken By _____ Date _____