

BLUE RIBBON CHIROPRACTIC

PATIENT INTRODUCTION FORM

Today's Date: _____, 20____

Name: _____ Soc. Sec. #: _____

Address: _____ Apt.# _____

City: _____ State: _____ Zip: _____ Gender: (M) (F) Date of Birth: ____/____/____

Home phone:(____) _____ Work phone:(____) _____ Cell phone:(____) _____

Occupation: _____ Employer: _____ EMAIL: _____

Head of household? (Y) (N) Number of children: _____ Marital status: (M) (S) (D) (W)

Spouse's Name: _____ Work phone:(____) _____ Cell phone:(____) _____

Activities/Sports/Hobbies: _____

Guardian's Name (if under 18): _____

Have you seen a Chiropractor before? (Y) (N) If so, when? _____ Referred here by: _____

IN CASE OF EMERGENCY

Nearest relative not living with you: _____ Phone:(____) _____ Relationship: _____

Contact that is not a relative: _____ Phone:(____) _____ Relationship: _____

Primary care physician: _____ Office phone:(____) _____

Address: _____ City: _____ State: _____ Zip: _____

MEDICAL HISTORY

(check all that apply, past or present symptoms)

- | | | |
|--|--|---|
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Stress | <input type="checkbox"/> Asthma |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Joint Pain | <input type="checkbox"/> Dizziness |
| <input type="checkbox"/> Leg Cramps | <input type="checkbox"/> Neck Pain | <input type="checkbox"/> Upper Backaches |
| <input type="checkbox"/> Weakness of Limbs | <input type="checkbox"/> Lower Backaches | <input type="checkbox"/> Nervousness |
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Fatigue (A.M)(P.M.) | <input type="checkbox"/> Digestive Problems |

Are you tired when you wake up? (Y) (N) Avg #hours sleep/night= _____ Stiff Neck

Pain Level right now=(1-best)(2)(3)(4)(5)(6)(7)(8)(9)(10-worst) Does pain/discomfort wake you up at night? (Y) (N)

Are you presently taking any medications? List: _____

List any accidents/traumas/surgeries & dates: _____

Any others not listed above? _____

Is there a family history of: Cancer Heart Disease Diabetes Other: _____

Females: Are you pregnant? (Y) (N)

Do you have health insurance? (Y) (N) Insurance company name: _____

NOTE: If you wish to have your chiropractic care billed to your insurance, please submit a copy of your insurance card.

****Please read the following carefully and sign that you understand and agree to the terms listed below.****

I have read and understand the financial policy statement of Blue Ribbon Chiropractic and Blue Ribbon Chiropractic has my full compliance.

I authorize the release of any information pertinent to my case to any insurance company or adjuster for purposes of obtaining payment for my bills.

I further authorize and direct my insurance company, listed above, to pay Blue Ribbon Chiropractic directly for services rendered to me.

In case of insurance, I understand that Blue Ribbon Chiropractic submits my claims to my carrier as a courtesy to me, the patient.

Furthermore, I understand that whatever amounts are not collected from insurance, I personally owe this office in full.

I understand that in the event of a returned check, a \$45 returned check fee will apply.

I acknowledge that I have received and read the Notice of Privacy Practices.

Patient Signature: _____ Date: _____, 20____

If patient is a minor: I hereby give my consent and permission for _____ to be treated in this office and furthermore agree to the above aforementioned.

Parent/Guardian's Signature: _____ Date: _____, 20____