

MONTALAND MCGRATH CHIROPRACTIC CENTER

Confidential Patient Information

Date _____

Name _____ Sex _____ DOB _____ Home Phone _____ Mobile _____

Address _____ City _____ State _____ Zip Code _____

Social Security # _____ Occupation _____ Company Name _____ Location _____ Work Phone # _____

Guardian's Full Name _____ Guardian's DOB _____ Guardian's social security # _____ Guardian's Employer _____ Location _____ Work Phone # _____

Name of nearest relative (not your spouse): _____ Phone # _____

Who referred you to the office? _____ To a certain Chiropractor? _____

Is your visit due to an accident? No Yes (if yes, please see the receptionist for an injury report) Email address: _____

YOUR PRESENT COMPLAINT _____

BRIEFLY DESCRIBE YOUR SYMPTOMS _____

List the other doctor(s) seen for this condition _____

Personal Medical History - if any of the following are relevant to your medical history, please check the accompanying box:

- | | | | | |
|--|---|--|--|------------------------------------|
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Muscular Dystrophy | <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Digestive Disorders | <input type="checkbox"/> Sciatica |
| <input type="checkbox"/> Polio | <input type="checkbox"/> Multiple Sclerosis | <input type="checkbox"/> Scarlet Fever | <input type="checkbox"/> Sinus Trouble | <input type="checkbox"/> Headache |
| <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Convulsions | <input type="checkbox"/> Nervousness | <input type="checkbox"/> Backaches | <input type="checkbox"/> Migraine |
| <input type="checkbox"/> High Blood pressure | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Asthma | <input type="checkbox"/> Numbness | <input type="checkbox"/> Shoulders |
| <input type="checkbox"/> Heart Trouble | <input type="checkbox"/> Concussion | <input type="checkbox"/> Dizziness | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Knees |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> German Measles | <input type="checkbox"/> Venereal Disease | <input type="checkbox"/> Hips |

Describe any operations you've had and the dates: _____

Have you been treated by a physician for any health condition in the last year? Yes No Primary care physician: _____

Describe Condition _____ Date of Last Physical Exam _____

Are you taking any medication? Yes No What kind? _____

Are you allergic to any medication? Yes No What kind? _____

Are you pregnant? Yes No Date of last menstrual period: _____

Do you have insurance? Yes No Insurance Company _____

ID. No. _____ Policy Group No. _____

I understand and agree that health and accident insurance policies are an arrangement between and insurance carrier and myself. Furthermore, I understand that this office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to this office will be credited to my account upon receipt. I permit this office to endorse co-issued remittances for the conveyance of credit to my account. 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. It is my understanding that my credit may be checked if Montaland McGrath Chiropractic center extends credit to me and I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered to me will be immediately due and payable unless prior arrangements are made, I hereby authorize the doctors at Montaland McGrath Chiropractic Center and whomever they may designate as their assistants to administer treatment as they so deem necessary and I also authorize the release of any information acquired in the course of my examination or treatment. I certify that the above information is true and correct.

Patient's (Parent or Guardian's) Signature _____