MONTALAND & MCGRATH CHIROPRACTIC CENTER

Confidential Patient Information

Date:_____

Is your visit due to an accident or work injury?_____ If so please see receptionist for an accident report form.

Name:_____ Sex:_____ Date of Birth:_____

Home Phone:_____ Cell Phone:_____ Work Phone:_____

Address:_____City:_____ State:_____ Zip:_____

Email:_____

Occupation:_____Company:_____Location:_____

If this is for a child under 18 please fill out the following.

Guardian's full name:_____ Date of Birth:_____ Social Security #:_____

Home Phone:_____ Cell Phone:_____ Work Phone:_____

Emergency Contact (not your spouse):_____Phone:_____

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

YOUR PRESENT COMPLAINT:_____

BRIEFLY DESCRIBE YOUR SYMPTOMS: _____ _____

_____

When did you first notice these symptoms?_____

List other doctor(s) you've seen for this condition:_____

Personal Medical History: If any of the following are relevant to your medical history, please check the box.

❑ Cancer	❑ Muscular Dystrophy	❑ Rheumatic Fever	❑ Digestive Disorders	❑ Sciatica
❑ Polio	❑ Multiple Sclerosis	❑ Scarlet Fever	❑ Sinus Trouble	❑ Headache
❑ Tuberculosis	❑ Convulsions	❑ Nervousness	❑ Backaches	❑ Migraine
❑ High Blood Pressure	❑ Epilepsy	❑ Asthma	❑ Numbness	❑ Shoulders
❑ Heart Trouble	❑ Concussion	❑ Dizziness	❑ Arthritis	❑ Knees
❑ Diabetes	❑ Hepatitis	❑ German Measles	❑ Venereal Disease	❑ 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? _____

Primary Doctor:_____Phone:_____

Describe Condition:_____ Date of Last Physical Exam:_____

Are you taking any medication?_____ What Kind?_____

Are you allergic to any medication?_____ What Kind?_____

Are you pregnant?_____ Estimated due date:_____Date of last menstrual period:_____

Do you have insurance?_____ Insurance Company:_____

Member ID #:_____Group #:_____Primary Card Holder Name:_____

I understand and agree that health and accident insurance policies are an arrangement between myself and the insurance carrier. 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 convenience 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:_____