FRISCO CHIROPRACTIC CENTER

TEXAS DRIVERS LICENSE # _____

NAME: _____ DATE: _____
(first) (middle) (maiden) (last)

HOME ADDRESS: _____ BIRTH DATE: _____
(street) (city) (state) (zipcode)

REFERRED BY:_____ HOME PHONE: _____

MOBILE PHONE_____ EMAIL : _____

EMPLOYER: _____ OCCUPATION: _____

NAME OF SPOUSE: _____ SPOUSE WORK PHONE: _____

NEAREST RELATIVE NOT LIVING WITH YOU:_____
(full name) (address) (phone)

SOCIAL SECURITY NUMBER: _____ SPOUSES SS#:_____

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PURPOSE OF THIS APPOINTMENT: _____

HOW LONG HAVE YOU HAD THIS PROBLEM?_____

DATE OF ACCIDENT / ONSET: _____ TIME: _____am\ pm **LOCATION:_____**

HOW DID ACCIDENT OCCUR? AUTO ON THE JOB OTHER:_____

PLEASE DESCRIBE THE CIRCUMSTANCES:_____

_____

HAVE YOU LOST TIME FROM WORK? YES NO DATES: _____
(from) (to)

HAVE YOU SEEN ANOTHER DOCTOR FOR THIS PROBLEM? YES NO NAME/SPECIALTY:_____

PREVIOUS ACCIDENTS: _____

PRIOR SURGERIES: _____

MEDICATIONS: _____

NAME / LOCATION OF PREVIOUS CHIROPRACTOR: _____ TREATED FOR: _____

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READ AND SIGN BELOW

WE ARE HAPPY TO FILE ANY APPLICABLE INSURANCE FOR YOU HOWEVER EVERY TYPE OF PLAN MAY HAVE LIMITATIONS IN VISITS ALLOWED OR DOLLAR AMOUNTS COVERED. WE WILL VERIFY YOUR PLAN AND INFORM YOU OF YOUR BENEFITS, BUT SHOULD YOU EXCEED THEM, YOU WILL BE BILLED FOR THE BALANCE. WE WILL NOT ACTIVELY KEEP UP WITH YOUR ONGOING STATUS BUT WILL BE HAPPY TO PROVIDE ANY REQUESTED INFORMATION YOU MAY REQUIRE TO DO SO.

By signing below, I also understand that Frisco Chiropractic Center may release my medical information as requested by my insurance company in order to process my health claims from this office. I also understand that if any other 3rd party entity to whom I have given permission, should request a copy of my medical information from this office, those records will also be provided.

_____ _____
Signature of Patient (or Parent/Guardian if patient is under 18) Date

(Please complete the other side)