Family First Chiropractic
and Wellness Center, LLC

PATIENT INFORMATION

Date_____
Name_____

Address_____
_____

Gender ___M ___F Age_____ DOB_____
____Single ____Married ____Widowed ____Divorced

Patient SS#_____
Occupation_____
Employer_____

Spouse's Name_____
Spouse DOB_____ Spouse SS#_____
Spouse Occupation_____
Spouse Employer_____

How did you hear about our office?
_____Referral Name_____
_____Ad ____Screening ____Lecture _____Other

Name of Medical Doctor_____
Facility_____ Phone_____

INSURANCE INFORMATION

Who is responsible for this account?_____
Relationship to patient_____
Insurance Company_____
Group #_____ Policy #_____

Is patient covered by additional insurance? ___Y ____N
Subscriber's Name_____
Birthdate_____ SS#_____
Relationship to patient_____
Insurance Company_____
Group #_____ Policy #_____

ASSIGNMENT AND RELEASE
I, the undersigned certify that I (or my dependent) have insurance coverage with the company listed above and assign directly to Dr. Carpenter (Family First Chiropractic and Wellness Center, LLC) all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

_____
Responsible Party Signature

_____ _____
Relationship Date

CONTACT INFORMATION

Phone (Home)_____(Work_)_____
(Cell)_____
E-mail address_____
Best time & place to reach you_____
IN CASE OF EMERGENCT, CONTACT:
Name_____ Relationship_____
Home_____ Work/Cell_____

ACCIDENT INFORMATION

Is condition due to an accident? ___Y _____N
Date_____
Type of accident
____Auto ____Work _____Home ____Other
To whom have you made a report of your accident?
___Auto Ins. ____Employer ____Worker Comp. ___Other
Attorney Name (if applicable)_____

PATIENT VISIT INFORMATION

Reason for visit_____
When did your symptoms appear?_____
Is this condition getting progressively worse? ____Y ____N _____Unknown
Mark an X on the picture where you continue to have pain, numbness or tingling.
Rate the severity of your pain on a scale from 1 (least pain) to 10 (severe pain)____
Type of pain: ____Sharp _____Dull _____Throbbing _____Numbness _____Aching
___Shooting ___Burning ___Tingling ___Cramps __Stiffness __Swelling ____Other
How often do you have this pain?_____
Is it constant or does it come and go?_____
Does it interfere with your ____Work ____Sleep ____Daily Routine ____Recreation
Activities or movements that are painful to perform: ____Sitting _____Standing ____Walking ___Bending ____Lying Down