DUNNELLON CHIROPRACTIC
Confidential Patient Health Record

DATE_____ PATIENT #_____
PERSONAL HISTORY

Name :_____
Address : _____
City : _____State_____Zip_____
Home Phone :_____Business Phone: _____ Cell Phone_____
Birthdate_____Age_____Sex____M___F___Race_____
Social Security Number : _____Email address : _____
Circle One : Married Single Widowed Divorced Separated # of Children _____
Business / Employer_____Occupation_____ Cell Carrier_____
Name of Spouse :_____ Spouse's Birthdate : _____
Spouse's Social Security Number :_____
Name and Number of Emergency Contact : _____
Referred To This Office By : _____
Who Is Responsible For Your Bill : Self_____ Spouse_____ Workman's Comp _____
Auto Insurance_____ Medicare_____ Medicaid _____ Other Health Insurance
(Name) _____
Purpose of This Appointment :_____
Other Doctors Seen For This Condition :_____ Who_____
When Did This Condition Begin _____
Is This Condition : Worker's Comp _____ Auto Related_____ Home Injury_____
Fall _____ Other _____
Date of Accident :_____
Have You Reported Your Accident To Your Employer: Yes____ No _____
Medication (s) / Drugs You Are Currently Taking :_____
_____
Do You Suffer From Any Condition Other Than That Which You Are Now Consulting Us? (Please Describe)_____Are you a smoker? ___How much_____
Major Surgery / Operations : _____
_____
Major Accidents or Falls: _____
Hospitalizations (other than above) : _____
Previous Chiropractic Care : No _____Yes____ if Yes, When, Last Doctor's (D.C.) Name and Telephone Number : _____
Allergies you have_____
Do you have a Pacemaker or Defibrillator? _____

Check Any of The Following Diseases You Have Had:

____ Appendicitis	**____ Malaria**	**_____Chicken Pox**
____Alcoholism	**___Scarlet Fever**	**_____ Tuberculosis**
____ Diabetes	**____ Veneral Infection**	**_____ Diptheria**
____ Cancer	**____ Arthritis**	**_____ Anemia**
____ Heart Disease	**_____ Stroke**	**_____ Epilepsy**
____ Pneumonia	**_____ Measles**	**_____ Goiter**
____ Mental Disorder	**_____ Mumps**	**_____ Polio**

Check Any of The Following You Have or Have Had In The Last 6 Months :

MUSCULO-SKELETAL	GASTROINTESTINAL	C-V-R
____ Low Back Pain	____ Excessive Thirst	___ Chest Pain
____ Shoulder Blade Pain	____ Poor/ Excessive Appetite	___ Shortness Breath
____ Neck Pain	____ Nausea	___ Blood Pressure
____ Arm Pain	____Vomiting	___ Irregular Rhythm
____ Joint Pain	____ Diarrhea	___ Heart Problems
____ Walking Problems	____ Constipation	___ Lung Problems
____ Jaw Pain	____ Liver Trouble	___ Ankle Swelling
____ Headaches	____ Gall Bladder	
____ Numbness	____ Weight Trouble	MALE/FEMALE
____ Dizziness	____ Black Stool	_____ Menstrual Irregularity
____ Forgetfulness	____ Bladder Trouble	_____ Breast Pain/Lumps
____ Fainting	____ Painful/Excessive	_____ Prostate /Sexual
____ Convulsions	Discolored Urine	Dysfunction
____ Cold/Tingling Extremities		ARE YOU PREGNANT ?
		_____ Yes _____ No

FAMILY HEALTH HISTORY (Many health problems are the result of hereditary factors)

Name	Relation	Health Problems

I understand and agree that health and accident Insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that Dunnellon Chiropractic 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 the Doctor's Office will be credited to my account on receipt. However, I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payments. If payment is not received from my Insurance Company within a reasonable amount of time, charges incurred are payable in full. Patient's are also responsible for the remaining charges not covered by the insurance company. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered me will be immediately due and payable. I will be responsible for any costs of collection, ,attorney's fees or court costs if required to collect my bill. I authorize payment of medical benefits to Dunnellon Chiropractic for services performed. I authorize the release of any medical or other information necessary to process my claims. I also request payment of government benefits either to myself or to the party who accepts assignment. I hereby authorize the Dunnellon Chiropractic its staff and physicians to treat my condition as deems necessary and appropriate. It is understood and agreed the amount paid the Dunnellon Chiropractic, for X-Rays, is for examination only and the X-Ray negatives will remain the property of this office, ,being on file where they may be seen at any time while a patient of this office. The patient also agrees that he/she is responsible for all bills incurred at this office. Dunnellon Chiropractic will not be held responsible for any pre-existing medically diagnosed conditions, nor for any medical diagnosis.

Patient's Signature : _____

Guardian or Parent : _____

Date : _____