Patient Information

PATIENT
Name:_____ S.S #_____ Home#:_____

Residential Address: _____ City:_____ State:____ Zip:_____

E-mail: _____ Cell#:_____ Age: _____ Birth Date: _____

Circle Marital Status: Married Single Widow Divorced Separated How many children? _____

WOMEN ONLY: Are you or is there any possibility you may be pregnant? Yes ❑ No ❑ Unsure ❑

How were you referred to our office? _____

EMPLOYER
Occupation:_____ Name:_____ Phone#:_____

Address: _____ City: _____ State: _____ Zip: _____

EMERGENCY CONTACT

Name: _____ Relationship: _____ Phone#:_____

Address: _____ City: _____ State: ____ Zip: _____

INSURED BY SPOUSE/PARENT

Name: _____ Date of Birth: _____ S.S #_____

Occupation: _____ Employer Name: _____

Have you ever had chiropractic care before? ❑ Yes ❑ No If yes when? _____

If you are experiencing any health problems please list your chief complaints in order of severity.

1. _____ How Long? _____
2. _____ How Long? _____
3. _____ How Long? _____

List other doctors consulted for these conditions:

1. _____ 2. _____

Family Physician's Name: _____ Phone#: _____

Is this related to a work injury or any other personal injury? Yes ❑ No❑ If yes describe_____

_____

Has it become? Same ❑ Better ❑ Worse ❑ If worse when and how?_____

_____

Have you had any broken bones? Yes ❑ No❑ If yes, List all broken bones & give dates _____

_____

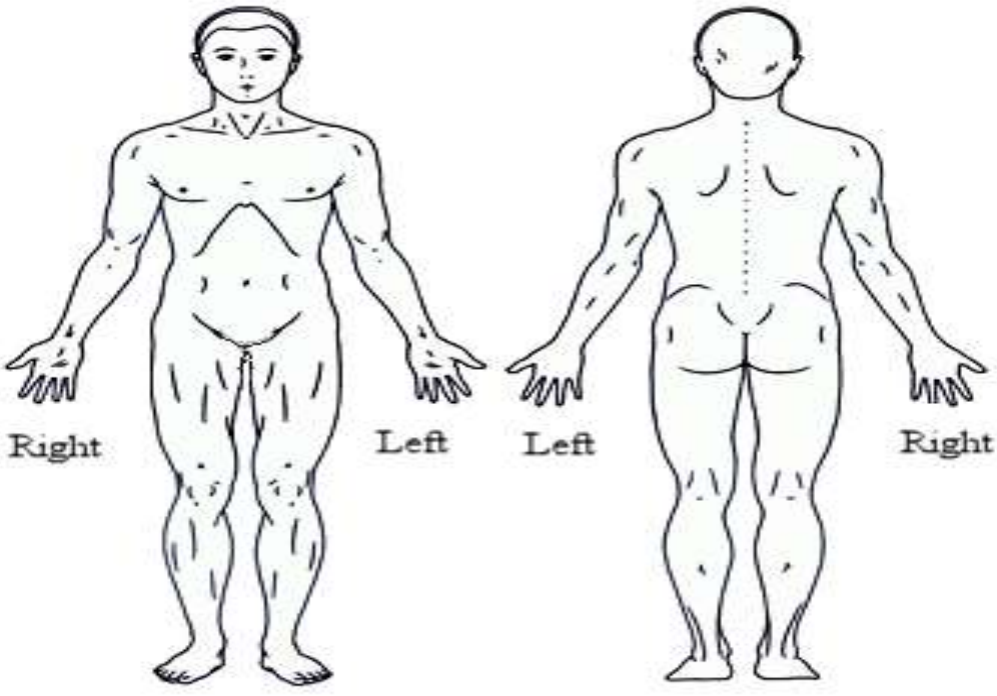
Serious illnesses/surgeries/hospitalizations you had? (Include dates) _____

_____Date of last physical examination:_____

What medications or drugs are you taking? ❑ Aspirin/Tylenol ❑ Pain Killers ❑Muscle Relaxants ❑ Insulin

❑ Tranquilizers ❑ Birth Control Pills ❑ Others: _____

Using the symbols below, mark on the pictures where you feel pain.



Please circle the pain level, 0 means no pain & 10 means severe pain. 0 1 2 3 4 5 6 7 8 9 10

Please check any and all insurance coverage that may be applicable in this case

❑ Insurance through yourself

❑ Insurance through □ Father/Mother □ Legal Guardian □ Spouse

❑ Worker's Compensation DOI: _____ ❑ Medicaid ❑ Medicare ❑ Cash ❑ Other_____

Name of Primary Insurance Co. _____

Name of Secondary Insurance Co._____

I authorize payment of insurance benefits directly to Steven R Davis DC. I authorize the doctor to release all information necessary to anyone we need to communicate with to secure the payment of benefits. I understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered me will immediately be due and payable. California State Law requires we maintain your X-Rays. The film itself is the property of this office. Films may be loaned to another facility with authorization only.

Patient's Signature:_____ Date: _____

Guardian's Signature Authorizing Care:_____ Date: _____