Green Chiropractic Office
Patient Intake Form

Name _____ **Male** __ **Female** __ **Single** __ **Married** __ **Widowed** __ **Divorced** __

How you prefer to be addressed _____ **Birthdate** _____/_____/_____ **Age**_____

Social Security # _____-_____- _____ **Drivers License #** _____ **State** _____

Street Address _____ **Home Phone** ____-____-_____

City _____ **State** _____ **Zip Code** _____- _____

Employer's Name _____ **What do you do there?** _____

Employer's Address _____ **Years with present employer** _____

Work Phone # _____-_____- _____ **Ext. #** _____ **Okay to call you at work?** **Yes** **No**

Referred to our office by _____

In Case of Emergency Contact _____ **Phone #** ____-_____-_____ **Relationship** _____

INSURANCE INFORMATION

Is your current condition the result of an accident/injury? **Yes** __ **No** ___ **If yes:** **Auto** __ **Work** __ **Slip/Fall** __

Primary Insurance Company

Ins. Co. Name _____ **Group # (Plan, Local or Policy #)** _____

Address _____ **Insured's Name** _____

_____ **Relation** _____ **Birthdate** _____

Ins. Co. Phone # _____ **Insured's Social Security #** _____

Insured' s Employer _____ **Address** _____

Secondary Insurance Company

Ins. Co. Name _____ **Group # (Plan, Local or Policy #)** _____

Address _____ **Insured's Name** _____

_____ **Relation** _____ **Birthdate** _____

Ins. Co. Phone # _____ **Insured's Social Security #** _____

Insured's Employer _____ **Address** _____

HEALTH HISTORY

List Any Allergies You May Have _____

_____

List Any Prescription/Non-prescription Medications You Are Taking _____

_____

List Any Non-prescription / Over the Counter Medications You Are Taking _____

_____

List Previous Surgeries With Dates _____

_____

List Any Serious Accidents / Injuries With Dates _____

_____

FOR WOMEN ONLY

Are You Taking Birth Control Pills? Yes ___ No ___

Are You Pregnant? Yes ___ No ___ If Yes, Expected Due Date _____

Are You Currently Nursing? Yes ___ No ___

We invite you to discuss frankly with us any questions regarding our services. The best chiropractic care is based on a friendly, mutual understanding between doctor and patient.

Our Office Policy requires payment in full for all chiropractic services rendered at the time of visit, unless other arrangements have been made with our business office. For your convenience this office may submit insurance claim forms to your designated insurance company on an assigned basis. Any and all charges not paid by the insurance company are the responsibility of the patient. If the account is not paid within 90 days of receipt of the statement, the patient will be responsible for any expenses incurred in collecting your account.

I hereby authorize payment of benefits directly to doctor of benefits due me for services rendered. I further authorize doctor to release any information required to process insurance claims.

I understand the above information and guarantee this form was completed to the best of my knowledge. I understand it is my responsibility to inform this office of any changes in my health status.

Signature of Patient (Responsible Person) _____ **Date** ____/_____/_____