

**PLEASE FILL THIS OUT COMPLETELY**  
**PLEASE PRINT**

Social Security No. \_\_\_\_\_  
Driver's License # \_\_\_\_\_  
Date \_\_\_\_\_

CONFIDENTIAL PATIENT INFORMATION

Name \_\_\_\_\_ Home Phone \_\_\_\_\_  
Address \_\_\_\_\_ City \_\_\_\_\_ Zip Code \_\_\_\_\_  
E-Mail Address \_\_\_\_\_ Cell Phone \_\_\_\_\_  
Age \_\_\_\_\_ Birth Date \_\_\_\_\_ Marital Status: M S W D How Many Children? \_\_\_\_\_  
Occupation \_\_\_\_\_ Employer \_\_\_\_\_  
Address \_\_\_\_\_ Office Phone \_\_\_\_\_  
Insurance Company \_\_\_\_\_ Agents Name \_\_\_\_\_ Policy # \_\_\_\_\_  
Name of Spouse \_\_\_\_\_ Spouse's Birth Date \_\_\_\_\_ Occupation \_\_\_\_\_  
Employer \_\_\_\_\_ Office Phone \_\_\_\_\_  
Patient's Nearest Relative \_\_\_\_\_ Address \_\_\_\_\_  
Referred by \_\_\_\_\_  
Date of Last Physical Examination \_\_\_\_\_

Have You Ever Suffered From:	YES	NO		YES	NO
1. Dizziness	<input type="checkbox"/>	<input type="checkbox"/>	8. Asthma	<input type="checkbox"/>	<input type="checkbox"/>
2. Backaches	<input type="checkbox"/>	<input type="checkbox"/>	9. Neuritis	<input type="checkbox"/>	<input type="checkbox"/>
3. Heart Trouble	<input type="checkbox"/>	<input type="checkbox"/>	10. Digestive Disorders	<input type="checkbox"/>	<input type="checkbox"/>
4. Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	11. Nervousness	<input type="checkbox"/>	<input type="checkbox"/>
5. Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>	12. Sinus Trouble	<input type="checkbox"/>	<input type="checkbox"/>
6. Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	13. Anemia	<input type="checkbox"/>	<input type="checkbox"/>
7. Headaches	<input type="checkbox"/>	<input type="checkbox"/>	14. Cancer	<input type="checkbox"/>	<input type="checkbox"/>

Purpose of this Appointment \_\_\_\_\_  
Other Doctors seen for this Condition \_\_\_\_\_  
Have you been treated for any health condition by a physician in the last year? \_\_\_\_\_  
Describe: \_\_\_\_\_  
Remarks and additional information: \_\_\_\_\_

**PAYMENT IS EXPECTED AT THE TIME OF VISIT!**

Name of Person Responsible for Payment: \_\_\_\_\_  
Are You Insured?  YES  NO Company: \_\_\_\_\_

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that the Beals Clinic of 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 Beals Clinic of Chiropractic 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 payment. I also understand that if I suspend or terminate my care and treatment, any outstanding fees for professional services rendered me will be immediately due and payable, and will be charged to my visa, discover, or master card.

Credit Card:  Visa  Discover  Master Card ID# (on back of card): \_\_\_\_\_

Credit Card #: \_\_\_\_\_ Expiration Date: \_\_\_\_\_

Delinquent accounts will be charged 18% Simple Annual Interest and/or all collection fees.

Patient's Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
Guardian or Spouse's Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
Information Taken By: \_\_\_\_\_ Date: \_\_\_\_\_