

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: _____