

Patient Information Sheet

Last Name: _____ First Name: _____ Middle: _____

Gender: M F Marital Status _____ Date of Birth: ___/___/___ Age: _____ SS#: _____

Home Address: _____

City: _____ State: _____ Zip: _____

Home #: _____ Work #: _____

Cell #: _____ E-mail: _____

Employer: _____

Insurance Company: _____

Insured's Name: _____ ID/Policy#: _____

Group #: _____ Phone #: _____

IMPORTANT: We verify insurance benefits as a courtesy; this is not a guarantee of benefits. We recommend you contact your insurance company to verify your coverage as well; it's your responsibility to thoroughly understand your insurance benefits. **Patient's Initials:** _____

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- | | | |
|--|---|---|
| <input type="checkbox"/> Headache | <input type="checkbox"/> Leg Pain/Tingling/Numbness | <input type="checkbox"/> Carpal Tunnel |
| <input type="checkbox"/> Neck Pain | <input type="checkbox"/> Arm Pain/Tingling/Numbness | <input type="checkbox"/> Ear Infections |
| <input type="checkbox"/> Upper Back Pain | <input type="checkbox"/> Shoulder Pain | <input type="checkbox"/> Frequent Colds/Flu |
| <input type="checkbox"/> Mid Back Pain | <input type="checkbox"/> Asthma | <input type="checkbox"/> Spinal Curvature |
| <input type="checkbox"/> Low Back Pain | <input type="checkbox"/> Allergies | <input type="checkbox"/> Digestive Problems |
| <input type="checkbox"/> Other _____ | | |

Other Chiropractor(s) you have seen? _____ When? _____

Who may we thank for referring you to Duke Family Chiropractic? _____

Have you had similar symptoms before? _____

Is this the result of an auto or work injury? _____ If so, when? _____

Family members with similar problems? _____ If so, when? _____

Do complaints interfere with your Work Sleep Hobbies Daily Routine? _____

Other Doctors you have seen for this problem? _____

Surgeries you have had: _____

Medications you are currently taking: _____

Is there any chance you are pregnant? Yes No First day of Last menstrual cycle: _____

Have you ever been diagnosed with cancer? Yes No IF so type: _____

I authorize Duke Family Chiropractic, PA to release any medical or other information necessary to process this claim. I clearly understand that all services rendered to me are charged to me and I am responsible for payment unless other arrangements are made. The above information is true and accurate to the best of my knowledge.

Patient Signature: _____ Date: _____