Mueller Chiropractic

Confidential Patient Information

710 Breckenridge Ln., Suite 201
Louisville, KY 40207
502-897-5181 Fax: 502-897-5122

Today's Date:____________________Your Social Security Number_____________________________________

Name:____________________________Home Phone:_____________________ Alt.Phone:___________________

Address:_____________________________ City:____________________ State:________ Zip:________________

Date of Birth:___________ Marital Status:_____Occupation:_________________ Email_____________________

Employer:______________________ Work Phone:__________________ Referred by:_______________________

Do you have Health Insurance? Y N Insurance company?____

When was your last examination?_______________________ Have you ever suffered from any of the following:

Headache Y N Low Back Pain Y N Heart Trouble Y N Dizziness Y N Cancer Y N Neck Pain Y N

Please list any and all surgeries you have undergone:____

____

Please list any and all medications you take now:____

____

Please list remarkable family health history I.E. parents or siblings, aunts, and uncles who have had strokes, heart attacks, cancer, diabetes, etc.____

____

Why are you consulting us at this time?____

How long have you had these issues?____

Is your health better, same or worse than it was this time last year?____

List other doctors you have seen for this same condition:____

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I understand and agree that health and accident insurance policies are an arrangement between my insurance carrier and me. I understand that all services rendered to me are charged directly to me and that I am personally responsible for payment. I understand that if I suspend or terminate my care, I will immediately settle any outstanding balance I have through credit extended to me for any and all professional services rendered to that point.

Patient's Signature:____ Date:___________________

Guardian's Signature (if patient is a minor)_____________________________ Date:___________________