

PATIENT PERSONAL/CONFIDENTIAL DATA

Date _____
Name _____
Address _____
City _____ State _____ Zip _____
Home Phone _____ Work Phone _____
Cell Number _____ e-mail _____
Sex M F Age _____ Birthdate _____
 Single Married Widowed Separated Divorced
Patient's SS# _____
Employer _____
Occupation _____
Employer's Address _____
Spouse/Parent Name _____
Spouse/Parent Employer _____
Spouse/Parent Work Phone _____
In case of an emergency Contact: _____
Phone _____
Whom may we thank for referring you? _____

INSURANCE INFORMATION

Who is responsible for this account? _____
Insured's Birthdate _____ SS# _____
Relationship to Patient _____
Ins Co _____ ID# _____
Is patient covered by additional insurance? Yes No
Ins Co _____ ID# _____

ASSIGNMENT AND RELEASE

I, the undersigned certify that I (or my dependant) have insurance coverage with _____ and assign directly to Dr. John D. Chiaf, D. C. all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Responsible Party Signature _____ Date _____

Medications: _____

PLEASE DESCRIBE PRESENT MAJOR COMPLAINTS:

Please Rate Your symptoms (1-10, with 1 being least serious and 10 being worst)

1. _____ 4. _____
2. _____ 5. _____
3. _____ 6. _____

SYMPTOMS DEVELOPED FROM: JOB INJURY AUTO ACCIDENT OTHER ILLNESS UNKNOWN

WHEN DID YOUR SYMPTOMS APPEAR? _____

SYMPTOMS ARE WORSE: MORNING AFTERNOON NIGHT SYMPTOMS: COME & GO CONSTANT
SYMPTOMS HAVE PERSISTED FOR # _____ HOUR(S) _____ DAY(S) _____ WEEK(S) _____ MONTH(S) _____ YEAR(S)
HAVE YOU EVER HAD THIS BEFORE: NO YES WHEN? _____
NAME AND LOCATION OF DOCTORS PREVIOUSLY SEEN FOR PRESENT CONDITION(S): _____

PLEASE CHECK THE ACTIVITIES THAT AGGRAVATE YOUR CONDITION:

BENDING REACHING STRAINING AT STOOL COUGHING SITTING TURNING HEAD
 LIFTING SNEEZING WALKING LYING DOWN STANDING

PLEASE CHECK THE ACTIVITIES THAT RELIEVE YOUR CONDITION:

BENDING SITTING LIFTING STANDING LYING DOWN TURNING HEAD REACHING WALKING

