SARASOTA CHIROPRACTIC CENTRE

3436 Bee Ridge Road * Sarasota, FL 34239 * (941) 922-2000

CONFIDENTIAL PATIENT INFORMATION Date:____________________

Name:____

Home Phone:______________ Cell:__________________ Email Address:____________________

Address:______________________________ City:________________ State:________ Zip:________

Age:____________ Birth date:_____________ Marital: M S W D No. of children:____________

Occupation:____________________________ Employer:____________________________

Address:_____________________________________ Office Phone:________________________

Name of Wife or Husband:______________________ Occupation:__________________________

Employer: ____________________________________ Office Phone:________________________

Patient's Nearest Relative:______________________ Phone:______________________________

Who may we thank for referring you?____

Date of last Physical Examination____

What operations have you had?_________________________________ When?______________

Serious Illnesss?____ When?______________

Have you ever suffered from:

1) Dizziness_________
2) Backaches________
3) Heart Trouble______
4) Diabetes__________
5) Turberculosis______
6) Arthritis_________
7) Headaches______
8) Numbness______
9) Asthma_________
10) Neuritis_________
11) Digestive Disorders____________
12) Nervousness_________________
13) Sinus Trouble________________
14) Anemia_____________________
15) Rheumatic Fever______________
16) Cancer_____________________

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? Yes ____ No _____

Describe____

What medications or drugs are you taking?____

Remarks and additional information____

Primary health care physician (PCP)____

PAYMENT IS EXPECTED AT 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 **Sarasota Chiropractic Centre** will prepare any necessary reports and forms to assist me in making collections from the insurance company and that any amount authorized to be paid directly to **Sarasota Chiropractic Centre** 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 fees for professional services rendered me will be immediately due and payable.

Patient's
Signature____ SS#__________________________ Date:______________

Guardian or Spouse's
Signature AuthorizingCare:____ Date:____________________

Information Taken
By:____ Date:___________________