Millville Chiropractic Center
1014 N High St, Millville, NJ, 08332-2527
(856) 327-0320

PATIENT INFORMATION & CONDITION FORM

Patient Name: ______________________________ Today's Date: ____________________

Social Security Number: ____________________ Birth Date: __________ Age: ________ Gender: ________

If you are under 18 years of age, who are your legal parents or guardian?

Father: ______________________________ Date of Birth: ___/___/___ Phone: (____) __________

Mother: ______________________________ Date of Birth: ___/___/___ Phone: (____) __________

Guardian: ______________________________ Date of Birth: ___/___/___ Phone: (____) __________

Marital Status: ____________________ How many children? ________

CURRENT ADDRESS:

Street: ____

City: ____

Phone: (Home) ______________________________ (Cell): ______________________________

E-Mail Address: ____

Your Occupation: ____________________ Employer: ____________________

Name of Spouse: ____________________ Spouse's Date of Birth: ____________________

Spouse's Occupation: ____________________ Spouse's Employer: ____________________

Spouse's Work Address: ____________________ Work Phone: ____________________

Who should we contact in the event of an emergency? ____________________ Phone ____________________

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How did you learn about us? ____

Is your condition or injury due to an accident or work-related cause? ☐ YES ☐ NO Please check ALL that apply.

Did the condition or injury result from *automobile* accident? ☐ YES ☐ NO

Did it result from a *work-related* accident or cause? ☐ YES ☐ NO (briefly describe): ____________________

____

Approximately, when did your injury or condition occur? ___/___/___

Describe your condition, symptoms, or the purpose of this appointment: ______________________________

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Have you ever had the same or similar condition? ☐ YES ☐ NO If yes, when and describe: ____________________

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Please indicate any other healthcare providers who you've seen for this injury or condition, and when you last saw them.

Name: ____________________ Type of Practice: ____________________ Date of Last Visit: ___/___/___

Name: ____________________ Type of Practice: ____________________ Date of Last Visit: ___/___/___

Date of last physical examination? ______________________________

List all surgeries have you had and when. ____

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Serious illnesses or conditions? ______________________ When? ______________

Have you been treated for any health condition by a physician in the last year? ☐ YES ☐ NO

Describe: ____

WOMEN ONLY: Are you pregnant or is there any possibility you may be pregnant? ☐ YES ☐ NO ☐ UNCERTAIN

What medications or drugs are you taking? ______________________

Have you ever suffered from:

☐ Dizziness	☐ Hernia	☐ Arthritis	☐ Asthma	☐ Digestive Disorders
☐ Backaches	☐ Neuritis	☐ Headaches	☐ Anemia	☐ Nervousness
☐ Heart Trouble	☐ Cancer	☐ Numbness	☐ Diabetes	☐ Sinus Trouble

Do you have health insurance? ☐ YES ☐ NO ☐ Not Sure Company: ______________________

Full Name of Policy Holder: ______________________ Policy Holder's Date of Birth ___/___/___

Does the policy holder have the insurance through his/her employer? ☐ YES ☐ NO

If yes, who is the employer? ______________________

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I have read and understand the following prior to signing. I hereby authorize Millville Chiropractic Center to furnish information concerning my condition and treatment to any insurance carrier. I further assign to Millville Chiropractic Center all payments any insurance carriers are obligated to make on my behalf for services rendered. I understand that payment for all medical services rendered is my responsibility and agree to pay promptly. I understand that my insurance may not cover all fees charged by Millville Chiropractic Center.

I certify that I have been informed that my preliminary authorization/precertification for payment obtained by Millville Chiropractic Center's office is not a guarantee of payment as per my insurance company's guidelines.

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and me. Furthermore, I understand that this chiropractic office 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 this chiropractic office by an insurance company will be credited to my account on receipt. However, I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. ANY UNPAID BALANCE ON INACTIVE ACCOUNTS OF 60 DAYS WILL BE SUBJECT TO COMPOUNDING INTEREST AT A RATE OF 1 ½% PER MONTH OR 18% ANNUALLY.

There will be a service charge of $25 for returned checks.

CERTAIN ASPECTS OF THIS COMMUNICATION CAN BE CONSTRUED TO BE AN ATTEMPT TO COLLECT A DEBT. THEREFORE, BE AWARE THAT ANY INFORMATION CONTAINED HEREIN MAY BE USED FOR THAT PURPOSE.

Patient's Signature: ______________________ Date: ___/___/___

Parent or Guardian Signature ______________________ Date ___/___/___

DOCTOR'S COMMENTS: ______________________

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