Fish Family Chiropractic

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New Patient Information

Name:_____ Date:_____
First MI Last
Address:_____ City:_____
State:_____ Zip: _____ Email Address_____
Cell Phone: _____ Cell Phone Carrier:_____ Home Phone: _____
Emergency Contact: _____ Emergency Phone: _____
Date of Birth: ___/___/____ Age: _____ Sex: **M F** Social Security #:_____ Marital Status: **M W D S**
Spouses Name:_____ Spouse's Employer:_____
Children's Names and Ages:_____
Student: Full time? ___ Part Time? ___ School:_____ Your Occupation:_____
Your Employer: _____ Work Address:_____
Previous Chiropractic Care? **Y N** Office: _____ Date Last Adjusted: __/__/___
I understand that I can achieve my best life with regular chiropractic care: **Y N**
I am here today because:_____
My family member/Friend brought me in/told me to come: _____
Tell us about your birth. How were you delivered: Vaginally C-Section Were you: Nursed Bottle-Fed?
Was your delivery assisted by: Forceps Vacuum Extraction
What are your hobbies: _____
My _____ hurts.
I suffer from _____
Have you had same or similar problem(s) before? _____ If so, for how long? _____
Father, Mother, Brother, Sister, Children with similar problems? _____
Other Doctors you have seen for this problem? _____
Surgeries you have had: _____
Medicines you currently take:_____
Is there a chance you are pregnant? _____
When was your most recent Auto Accident? _____
When was the one before that? _____
Method of Payment for this Visit? Cash Check Credit
Do you have insurance that will help you pay for your bill? **Y N**

Authorization

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize Fish Family Chiropractic to release any information including the diagnosis and the records of any treatment or examination rendered to me or my children during the period of such chiropractic care to third party payers and or health practitioners. I authorize my insurance company/attorney to make payment directly to my chiropractor. I understand that the bill in its entirety is my responsibility and that I agree to pay any remaining balance following third party reimbursement so that my bill is paid in full.
I give permission for FFC to display my family's photos in the office and on our social media accounts.

X_____

Get HOOKED on Chiropractic

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