Social Security No. _____
Driver's License # _____
Date _____

CONFIDENTIAL PATIENT INFORMATION

E-MAIL _____

Name _____ Home Phone _____ CELL _____
Address _____ Zip code _____
Age _____ Birth Date _____ Marital Status: M S W D How many children? _____
Occupation _____ Employer _____
Address _____ Office Phone _____
Insurance Company _____ Agents Name _____ Policy # _____
Name of Wife or Husband _____ Occupation _____
Employer _____ Office Phone _____
Patient's Nearest Relative
Address _____
Referred by _____
Date of Last Physical Examination _____ FAMILY DOCTOR _____

Have You Ever Suffered From:	YES	NO		YES	NO
1. Dizziness	☐	☐	8. Asthma	☐	☐
2. Backaches	☐	☐	9. Neuritis	☐	☐
3. Heart Trouble	☐	☐	10. Digestive Disorders	☐	☐
4. Diabetes	☐	☐	11. Nervousness	☐	☐
5. Tuberculosis	☐	☐	12. Sinus Trouble	☐	☐
6. Arthritis	☐	☐	13. Anemia	☐	☐
7. Headaches	☐	☐	14. 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 _____
Remarks and additional information _____
_____

PAYMENT IS EXPECTED AT THE 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 the OZARK CHIROPRACTIC CLINIC will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to the OZARK CHIROPRACTIC CLINIC 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: _____ Date: _____
Guardian or Spouse's Signature: _____ Date: _____
Information Taken By: _____ Date: _____