adults . children . pregnancy

CRAM

CHIROPRACTIC and WELLNESS CENTER

Patient Introduction

Personal History:

Patient Name: _____
First Middle Last

Address:

Street: _____

City, State, Zip: _____

Telephone: Home: _____ Work: _____

Cell: _____

Social Security #: _____

Birth Date: Month: _____ Day: _____ Year: _____

Occupation: _____

Employer: _____

Marital Status: _____ **If Yes**/Spouse's Name: _____

Referred to our Center by: _____

Medical Information:

Previous Chiropractor: _____ City: _____

Last visit to this Chiropractor: _____

Reason for leaving:

_____

_____

Present MD: _____ City: _____

Please note that if you have been involved in a motor vehicle accident, our fee structure may differ due to the complexity of your needs in such cases.

I fully understand the fees and give my consent. I also give my consent to have the doctor request any x-rays he/she deems appropriate to better understand my problem and monitor my progress.

Our policy requires payment in full for all services rendered at the time of visit, unless other arrangements have been made with the business manager. If account is not paid within 90 days of the date of service and no financial arrangements have been made, you will be responsible for legal fees, collection agency fees, interest charges and any other expenses incurred in collecting your account.

I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any charges to the information I have provided.

SIGNATURE: _____
(Signature of Parent/Guardian required if patient under age 18)

DATE: _____

Thank You!