

Welcome To Graves Family Chiropractic

Patient Information

Date: _____
First Name: _____
Last Name: _____
Called Name: _____
Address: _____
City & Zip: _____
Home Phone: _____
Work Phone: _____
Cell Phone: _____
Email: _____
Sex: M F Age: _____
Birth date: _____
Single Married
SS#: _____
Employer: _____
Spouse's Name: _____
Spouse's Employer: _____
Who may we thank for referring you?

Accident Information

Is condition due to an accident? Y/N
If yes, date of accident: _____
Type of accident:
Auto Work Home
To whom have you made a report of your
accident?: Auto Insurance Employer
Worker's Comp Other
Attorney Name:

Attorney Phone #: _____

Insurance Information

Who is responsible for this account?

Relationship to patient: _____
Insurance Company: _____
Group #: _____
Birthdate: _____
SS#: _____
Subscriber's name: _____
Is patient covered by additional insurance?
Y/N
Relationship to patient: _____
Insurance Company: _____
Group #: _____
Birthdate: _____
SS#: _____

ASSIGNMENT AND RELEASE

I, the undersigned certify that I (or my dependent) have insurance coverage with _____
and assign directly to Paul Graves, D.C., P.A. all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Responsible Party Signature

Relationship

Date

Patient Number: _____

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Health History

Circle "Yes" or "No" to indicate if you have had any of the following:

AIDS/HIV	Y/N	Glaucoma	Y/N	Parkinson's Disease	Y/N
Alcoholism	Y/N	Goiter	Y/N	Pinched Nerve	Y/N
Allergy Shots	Y/N	Gonorrhea	Y/N	Pneumonia	Y/N
Anemia	Y/N	Gout	Y/N	Polio	Y/N
Anorexia	Y/N	Heart Disease	Y/N	Prostate Problems	Y/N
Appendicitis	Y/N	Hepatitis	Y/N	Prosthesis	Y/N
Arthritis	Y/N	Hernia	Y/N	Psychiatric Care	Y/N
Asthma	Y/N	Herniated Disk	Y/N	Rheumatoid Arthritis	Y/N
Bleeding Disorders	Y/N	Herpes	Y/N	Rheumatic Fever	Y/N
Breast Lump	Y/N	High Cholesterol	Y/N	Scarlet Fever	Y/N
Bronchitis	Y/N	Kidney Disease	Y/N	Stroke	Y/N
Bulimia	Y/N	Liver Disease	Y/N	Suicide Attempt	Y/N
Cancer	Y/N	Measles	Y/N	Thyroid Problems	Y/N
Cataracts	Y/N	Migraines	Y/N	Tonsillitis	Y/N
Chemical Dependency	Y/N	Miscarriage	Y/N	Tuberculosis	Y/N
Chicken Pox	Y/N	Mononucleosis	Y/N	Tumors/Growths	Y/N
Diabetes	Y/N	Multiple Sclerosis	Y/N	Typhoid Fever	Y/N
Emphysema	Y/N	Mumps	Y/N	Ulcers	Y/N
Epilepsy	Y/N	Osteoporosis	Y/N	Vaginal Infections	Y/N
Fractures	Y/N	Pacemaker	Y/N	Venereal Disease	Y/N
				Whooping Cough	Y/N

Other: _____

Exercise	Work	Habits	
Daily	Light Labor	Coffee/Caffeine	Cups/Day _____
None	Sitting	Smoking	Packs/Week _____
Moderate	Standing	Alcohol	Drinks/Week _____
Heavy	Heavy Labor	High Stress Level	Reason _____

Injuries/Surgeries you've had:	Description	Date
Falls:	_____	_____
Head Injuries:	_____	_____
Broken Bones:	_____	_____
Dislocations	_____	_____
Surgeries:	_____	_____

Medications	Allergies	Vitamins/Herbs/Minerals
_____	_____	_____
_____	_____	_____
_____	_____	_____

Are you pregnant? Yes No Due Date: _____
 Pharmacy Name: _____
 Pharmacy Phone: _____

Patient Number: _____