SSN#: ____________________
Driver's License #: ____________________
Date: ____________________
Email: ____________________

CONFIDENTIAL PATIENT INFORMATION

Name ______________________________ Home Phone ____________________
Cell Phone ____________________ Work Phone ____________________
Address ____________________City__________State______ Zip Code__________
Age_______ Birth Date_____/_____/_____ Martial Status: M S W D How many children? _______
Occupation ____________________ Employer ____________________
Address ____________________ Office Phone ____________________
Insurance Company ______________ Agents Name __________ Policy #__________
Name of Spouse ______________ Occupation ____________________
Employer ____________________ Office Phone ____________________
Patient's Nearest Relative
Address ____
Referred by ____
Date of Last Physical Examination ____

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 Bazil Chiropractic Health Center 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 Bazil Chiropractic Health Center 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: ______________