KELLEY / McILNAY CHIROPRACTIC

CONFIDENTIAL PATIENT INFORMATION

NAME: _____ SS#:_____-_____-_____
PRIM LANGUAGE: _____ INTERPRETER REQUIRED? YES / NO (CIRCLE ONE)
ADDRESS:_____ CITY:_____ ZIP:_____
PHONE: (____)_____ CELL CARRIER:_____BIRTHDATE:____/____/____ AGE:_____
E-MAIL ADDRESS: _____MARITAL STATUS: M S W D
OCCUPATION:_____EMPLOYER:_____WORK PHONE: (_____)_____
WK ADDRESS: _____CITY:_____ZIP:_____
NAME OF SPOUSE:_____SPOUSE'S OCCUPATION_____
EMERGENCY CONTACT:_____PHONE: (_____) _____
REFERRED BY:_____

DATE OF LAST PHYSICAL EXAM: _____HEIGHT:_____WEIGHT:_____
WHAT SURGERIES HAVE YOU HAD?_____WHEN? _____
SERIOUS ILLNESSES:_____WHEN? _____
HAVE YOU BEEN TREATED FOR ANY HEALTH CONDITIONS BY A PHYSICIAN IN THE LAST YEAR?
☐**NO** ☐**YES** PLEASE DESCRIBE: _____
ARE YOU CURRENTLY PREGNANT?
☐**NO** ☐**YES** IF YES, WHAT IS YOUR DUE DATE?: _____
HAVE YOU EVER SUFFERED FROM:
DIZZINESS:_____ARTHRITIS:_____NERVOUSNESS: _____
BACKACHES:_____HEADACHES:_____SINUS TROUBLE:_____
HEART TROUBLE:_____NUMBNESS:_____ANEMIA: _____
DIABETES:_____TINGLING:_____RHEUMATIC FEVER: _____
ASTHMA:_____CANCER: _____
DIGESTIVE DISORDER: _____

PURPOSE OF APPOINTMENT:_____
WHEN SYMPTOMS BEGAN: _____HOW SYMPTOMS BEGAN: _____
OTHER DOCTORS SEEN FOR THIS CONDITION: _____
WHAT MEDICATIONS OR DRUGS ARE YOU TAKING? _____

PAYMENT IS EXPECTED AT TIME OF VISIT! A $50 FEE WILL BE CHARGED IF A 24-HOUR NOTICE OF CANCELLATION IS NOT GIVEN OR YOU DO NOT SHOW FOR YOUR SCHEDULED APPOINTMENT.

NAME OF PERSON RESPONSIBLE FOR PAYMENT:_____
ARE YOU INSURED? ☐**NO** ☐**YES** **INSURANCE COMPANY:** _____

I UNDERSTAND AND AGREE THAT HEALTH AND ACCIDENT INSURANCE POLICIES ARE AN ARRANGEMENT BETWEEN THE INSURANCE CARRIER AND MYSELF. FURTHERMORE, I UNDERSTAND THAT THE DOCTOR'S OFFICE WILL PREPARE ANY NECESSARY REPORTS AND FORMS TO ASSIST ME IN MAKING COLLECTIONS FROM THE INSURANCE COMPANY AND THAT ANY AMOUNT AUTHORIZED TO BE PAID DIRECTLY TO THE DOCTOR'S OFFICE WILL BE CREDITED TO MY ACCOUNT ON RECEIPT. HOWEVER, I CLEARLY UNDERSTAND 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 TO ME WILL BE IMMEDIATELY DUE AND PAYABLE.

PATIENT'S SIGNATURE:_____DATE: _____
SIGNATURE OF PARENT OR GUARDIAN:_____DATE: _____