SARASOTA CHIROPRACTIC CENTRE

3532 Fruitville Road * Sarasota, FL 34237 * (941) 922-2000

CONFIDENTIAL PATIENT INFORMATION Date:_____

Name:_____

Home Phone:_____ Cell:_____Email Address:_____

Address:_____City:_____State:_____Zip:_____

Age:_____Birth date:_____ Marital: M S W D No. of children:_____

Occupation:_____ Employer:_____

Address:_____ Office Phone:_____

Name of Wife or Husband:_____ Occupation:_____

Employer: _____ Office Phone:_____

Patient's Nearest Relative:_____ Phone:_____

Who may we thank for referring you?_____

Date of last Physical Examination_____

What operations have you had?_____When?_____

Serious Illnesss?_____When?_____

Have you ever suffered from:

1)

Dizziness_____ 6) Arthritis_____ 11) Digestive Disorders_____

2)

Backaches_____ 7) Headaches_____ 12) Nervousness_____

3)

Heart Trouble_____ 8) Numbness_____ 13) Sinus Trouble_____

4)

Diabetes_____ 9) Asthma_____ 14) Anemia_____

5)

Turberculosis_____ 10) Neuritis_____ 15) Rheumatic Fever_____

16)

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_____

What medications or drugs are you taking?_____

Remarks and additional information_____

Primary health care physician (PCP)_____

PAYMENT IS EXPECTED AT 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 **Sarasota Chiropractic Centre** 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 **Sarasota Chiropractic Centre** 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_____SS#_____Date:_____

Guardian or Spouse's

Signature AuthorizingCare:_____Date:_____

Information Taken

By:_____Date:_____

Rev. 2/05 New patient intake form