

PATIENT INFORMATION

Date _____

Patient _____ Sex: M _____ F _____ Age _____

Address _____ Apt# _____ Birthdate _____

City _____ State _____ Zip _____

Single _____ Married _____ Widowed _____ Separated _____ Divorced _____

Patient SSN# _____ Occupation _____

Employer _____ Employer Address _____

Spouse's Name _____ Spouse's Birthdate _____

Spouse's Employer _____ Spouse's SSN# _____

Referred to our office by: _____

PHONE NUMBERS

Home _____ Work _____ Ext. _____ Cell _____

Best time to reach you _____ Where _____

Email Address _____

IN CASE OF EMERGENCY, CONTACT

Name _____ Relationship to patient _____

Home Phone _____ Work Phone _____

INSURANCE

Who is responsible for this account? _____

Relationship to Patient _____

Insurance Co. _____ Subscriber Name _____

Member ID # _____ Group # _____

Is patient covered by Secondary Insurance Co.? Yes _____ No _____

Name of Secondary Insurance Co. _____

Name of Subscriber _____ Birthdate _____

Member ID # _____ Group # _____

ASSIGNMENT AND RELEASE

I, the undersigned certify that I (or my dependent) have insurance with the above named insurance company and assign directly to Dr. Blake Bennett 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 my 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.

_____ Date _____

Responsible Party Signature

PATIENT CONDITION

Reason for visit? _____

When did your symptoms first appear? _____

What caused your condition? _____

Is this condition getting progressively worse? Yes No Unknown

Rate the severity of your pain on a scale 1 (least pain) to 10 (severe pain) _____

Type of pain: Sharp Dull Throbbing Numbness Aching Shooting
 Burning Tingling Stiffness Swelling Other _____

How often do you have the pain (constant, daily, weekly, monthly, etc.)? _____

What activities or movements make it worse? _____

What makes it better? _____

My symptoms are interfering with my: Work Sleep Daily Routine Recreation

Was this condition due to an accident? Yes No

If Yes, Date of Accident? _____

Type of Accident: Auto Work Home Other

Do you have an attorney for this accident? Yes No

If Yes, name of attorney _____ Firm Name _____

HEALTH HISTORY

What treatment have you received for this condition? _____

Other doctors seen for this condition _____

Date of Last: Physical Exam _____
Spinal Exam _____

Spinal X-Ray _____
MRI, CT, Bone Scan _____

List any other conditions that we should be made aware of regarding your health (High blood pressure, Diabetes, Cancer, etc.) _____

Exercise: None Very Little Moderate Heavy

Work Activity: Sitting Standing Light Labor Heavy Labor

Habits: _____ Smoking (packs/day) _____ Alcohol (drinks/week)
_____ Caffeine Drinks (cups/day) _____ High Stress (reason)

List any past surgeries AND injuries that you have had and the date they happened _____

What medications are you taking? _____

Have you seen a chiropractor before? No Yes: Date of last adjustment _____

Is there anything else you would like us to know that would help us help you? _____