CONFIDENTIAL

PATIENT INFORMATION SHEET

Please Print Clearly and Fill Out Completely

ELLYSON CHIROPRACTIC

Patient Name: _____

Address: _____

City/State/Zip: _____

Home Phone: _____

Cell Phone: _____

Last Four Numbers of Your
Social Security Number: XXX-XX- __ __ __ __

Drivers License Number: _____

Date of Birth: _____

Sex: M F Marital Status: M S W D

Number of Children: _____

E-Mail Address: _____

Occupation: _____

Employer: _____

Address: _____

City/State/Zip: _____

Work Phone: _____

Referred By: _____

Emergency Contact: _____

Address: _____

Phone: _____

Name of Spouse: _____

Occupation: _____

Employer: _____

Guarantor (if minor): _____

Address: _____

City/State/Zip: _____

Phone Number: _____

Last Four Numbers of Your
Social Security Number: XXX-XX- __ __ __ __

Drivers License Number: _____

Relationship to Patient: _____

Date of Last Physical Examination: _____

Previous Chiropractor: _____

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

Please Describe: _____

_____

Have you ever suffered from:

- ☐ Dizziness
- ☐ Tuberculosis
- ☐ Neuritis
- ☐ Nervousness
- ☐ Diabetes
- ☐ Asthma
- ☐ Sinus Trouble
- ☐ Heart Trouble
- ☐ Headaches
- ☐ Digestive Disorders
- ☐ Backaches
- ☐ Arthritis
- ☐ Anemia
- ☐ Rheumatic Fever

Remarks/Additional Information: _____

_____

Primary Insurance: _____

ID No.: _____ Group No.: _____

Secondary Insurance: _____

ID No.: _____ Group No.: _____

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that the Ellyson Chiropractic Office 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 the Ellyson Chiropractic Office 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 understand that a handling fee will be charged to my account for any returned check and that in the event Ellyson Chiropractic Office should find it necessary to refer my account to a collection service, I will be charged a delinquent fee of 15% of the total bill or $15.00, whichever is greater. 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/Guarantor Signature: _____ Date: _____

CONFIDENTIAL

IF YOURS IS AN ACCIDENTAL INJURY

Please Complete the Following Questions

ELLYSON CHIROPRACTIC

Date of Accident:_____ Hour:_____ ☐ AM ☐ PM Location:_____

How did the Accident Occur? ☐ Auto Collision ☐ On-the-Job Injury ☐ Other_____

Please Describe:_____

Did you report the injury to your foreman or employer? ☐ Yes ☐ No

Did they recommend care at our office? ☐ Yes ☐ No

If auto accident were you ☐ Driver ☐ Passenger ☐ Pedestrian

If auto collision were you struck from ☐ Behind ☐ Right Side ☐ Left Side ☐ Front ☐ Auto was parked

Did your car strike the other (s) involve? ☐ Yes ☐ No

Or did the car strike yours? ☐ Yes ☐ No ☐ Undetermined

As a result of the accident, were traffic citations issued to you? ☐ Yes ☐ No

To the driver of the other car? ☐ Yes ☐ No

To the driver of your car? ☐ Yes ☐ No

List the extent of the injuries as you know them: _____

Did you require post-accident hospitalization? ☐ Yes ☐ No

Check symptoms you have noticed since accident:

☐ Headaches	☐ Dizziness	☐ Light Bothers Eyes	☐ Diarrhea
☐ Neck Pain	☐ Head Seems too Heavy	☐ Loss of Memory	☐ Feet Cold
☐ Neck Stiff	☐ Pins & Needles in Arms	☐ Ears Ring	☐ Hands Cold
☐ Sleeping Problems	☐ Pins & Needles in Legs	☐ Face Flushed	☐ Stomach Upset
☐ Back Pain	☐ Numbness in Fingers	☐ Buzzing in Ears	☐ Constipation
☐ Nervousness	☐ Numbness in Toes	☐ Loss of Balance	☐ Cold Sweats
☐ Tension	☐ Shortness of Breath	☐ Fainting	☐ Fever
☐ Irritability	☐ Fatigue	☐ Loss of Smell	☐ _____
☐ Chest Pain	☐ Depression	☐ Loss of Taste	☐ _____

Symptoms other than above:_____

Have you lost any days of work?_____ Dates: _____

Insurance Companies involved: _____

My Company: _____

Company of person responsible for injuries:_____

Have you been contacted by an insurance adjuster or company representative regarding this claim? ☐ Yes ☐ No

Do you have an attorney that has advised you in this case? ☐ Yes ☐ No

Name:_____

Address:_____ Telephone: _____