

Schneider Chiropractic, 81 Glen Rd. Garner NC, 27529 (919)661-2225

CONFIDENTIAL PATIENT HISTORY FORM

Please answer all questions or write N/A (if it does not apply)-Thanks!

Confidential Health History:

Today's Date:

Name:

Soc. Sec. #

Home Phone:

Address:

City:

State:

Zip:

Age:

Birthdate:

Male Female

Status:

M S W D

of Children:

Occupation:

Employer:

Work Phone:

E-Mail Address

Spouse Name:

Spouse's Occupation:

Spouse Employer:

Town:

Work Phone:

Name of person whose policy you are on:

Their Date of Birth:

In Case of Emergency:

Who is your nearest living relative (for emergency use please list name/address/phone):

Please answer all question or enter N/A if it does not apply -- Thank you

2. any surgery (list type and date) Yes No

If yes:

3. any significant falls/fractures in your lifetime(list type and date)? Yes No

If yes:

4. any automobile / job accidents? Y N If yes, When?

5. Did you receive any treatment? Y N. For which accident? By Whom & for which accident?

If your injury is job related:

Are you working now? Y N . Have you lost any work days? Y N

If yes, what days have you lost ?

Was the injury reported to your supervisor and an incident report made? Y N

Have you been unable to resume work due to this injury? Y N

6. Have you been treated by a Dr. for any health conditions in the last year? Y N

If yes, what were they?:

7. Are you taking any medication Y N . (List:name, dosage, Dr. and reason prescribed)

*please spell drug name correctly (refer to bottle or prescription)

If yes,

Drug	Dosage	Dr.	Reason
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Any others?:

List over the counter medications here:

8. If you have a family medical doctor/clinic that you use, please note:

Name town/location

phone #

***** For women only:** The following information is essential in order to determine if x-rays can be taken and what treatment procedures will assure you the greatest results and safety.-Thank you!

Are you pregnant at this time ? Y N .

Are you trying to become pregnant at this time? Y N

Are you taking any medication,(including birth control) Y N .

Explain?

Do you smoke at all? Y N . If yes... How much?

*Please note: In order to keep care as affordable as possible by reducing billing expenses, our office policy requires that payment be made at the time of your office visit .

What method of payment will you be using today?

Cash Check Credit card

I hereby authorize Dr. Bruce Schneider or his assistants to examine me and take any x-rays deemed necessary by the Doctor. I further authorize any treatment deemed necessary by the Doctor for myself (or my children ,if applicable). I authorize the Doctor to release or obtain my records to/from my insurance company, attorney, or my other doctors, if needed. *** If I am a female patient, I will notify the Doctor of any chance that I may be pregnant before any x-rays are ever taken and before any treatment is administered.)*** If I have health insurance and use it for chiropractic services, I accept that any unpaid balance is my responsibility, which includes deductibles, co-payments and any services that my insurance company decides not to pay for, regardless of their reason. This applies to automobile and work related injury cases as well. I request that my insurance benefits be assigned to the doctor. Any collection costs incurred on my account are my responsibility. I certify that the above information is accurate and truthful, that I understand the policies of the office and that I present to Dr. Schneider for evaluation and/or treatment of a health related condition and for no other purpose. Copies of x-rays or records will be at my expense and require 1 weeks written notice.

Signature of Patient _____

If patient is a minor, Signature of parent and/or guardian _____

Witness by: _____ date: ____/____/____

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