

## PATIENT DATA SHEET

First Name \_\_\_\_\_ Middle Initial \_\_\_\_\_ Account Number \_\_\_\_\_

Last Name \_\_\_\_\_ Called Name \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

Birthdate \_\_\_\_\_ Social Security Number \_\_\_\_\_

E-mail Address \_\_\_\_\_ Drivers License Number \_\_\_\_\_

Sex: Male Female Marital Status: Single Married Divorced Widowed Spouse's Name \_\_\_\_\_

Children's Names and Ages \_\_\_\_\_

How did you hear about our office: Friend (name) \_\_\_\_\_

Please circle (if applicable) Drive-by Yellow Pages: Bellsouth Upstate Directory Talking Phone Book

Work Status: Retired Employed Unemployed Full-time student Part-time student Other \_\_\_\_\_

### **Patient Employer Information**

Employer \_\_\_\_\_ Address \_\_\_\_\_

City, State, Zip \_\_\_\_\_ Phone number \_\_\_\_\_

Type of Work: \_\_\_\_\_ How long at this job \_\_\_\_\_ Are you required to lift \_\_\_\_\_

Are you required to: \_\_\_\_\_sit \_\_\_\_\_stand \_\_\_\_\_walk \_\_\_\_\_travel \_\_\_\_\_work at a computer

Do you wear a support back brace? Yes No Is it required? Yes No Is it available Yes No

What type of work did you do before this job? \_\_\_\_\_

Have you ever had a work related accident? Yes No Date \_\_\_\_\_ Type of injury \_\_\_\_\_

Was the injury reported to your employer? Yes No Type of Treatment: \_\_\_\_\_

### **Responsible Party (if patient is a minor child)**

First Name \_\_\_\_\_ Last Name \_\_\_\_\_ SSN: \_\_\_\_\_

Address \_\_\_\_\_ City, State, Zip \_\_\_\_\_

Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

**Insured's Information (if other than patient)**

Patient is: Spouse Child Other

First Name \_\_\_\_\_ Last Name \_\_\_\_\_ Male Female

Address \_\_\_\_\_ City, State, Zip \_\_\_\_\_

Phone number \_\_\_\_\_ SSN: \_\_\_\_\_ Birthdate \_\_\_\_\_

**Insured's Employer Information**

Employer \_\_\_\_\_ Phone Number \_\_\_\_\_

Address \_\_\_\_\_ City, State, Zip \_\_\_\_\_

**Please fill out the following information completely**

Please list your major complaint \_\_\_\_\_

When were you first aware of the problem \_\_\_\_\_

Probable cause \_\_\_\_\_

Is this your first visit to a Chiropractic office? Yes No Name of previous Chiropractor \_\_\_\_\_

**Please read and sign below**

I understand that payment is due and expected today at the time services are rendered. I understand any necessary x-rays remain the property of this office. I authorize Ehlich Family Chiropractic to release any information regarding my care here necessary to process my insurance claims. I assign the benefits of my health insurance to this office. I understand that an interest charge will be applied to any outstanding balances that I am responsible for after 30 days.

**I understand that all insurance takes up to 48 hours to verify, and that I am responsible for all charges for services rendered on my first day in this office.**

I have read and agree to the above statements.

Patient signature \_\_\_\_\_ Date \_\_\_\_\_

Parent signature (if patient is a minor) \_\_\_\_\_ Date \_\_\_\_\_

**Please complete the following ONLY if your visit today is due to an accident**

Is your major complaint due to an: \_\_\_\_\_ auto accident \_\_\_\_\_ work injury \_\_\_\_\_ slip or fall

Date of accident \_\_\_\_\_ Time \_\_\_\_\_ Location \_\_\_\_\_

Describe the accident \_\_\_\_\_

Person or Business at fault: \_\_\_\_\_ Insurance Company \_\_\_\_\_

Your insurance company \_\_\_\_\_ Do you have an Attorney? Yes No

Attorney Name \_\_\_\_\_ Phone number \_\_\_\_\_