Confidential Patient Information

The following information is needed for our files so we can better serve you as a patient.
PLEASE PRINT

Patient's full name_____

Address_____

Mailing Address_____

City, State & Zip_____

Birth date_____ Social Security number_____

Home phone (____)_____ Sex: Male Female
Cell phone (____)_____

Marital status: single married widowed divorced other: _____
Date of last menstrual period_____

Nearest relative_____ phone number_____

Reason for visit:
Related to employment Yes No Date_____
Related to Automobile Yes No Date_____
Related to other Yes No Date_____

History Information

Have you had any past illness? Yes No
Please list_____

Family Physicians name: _____
Physicians phone number: _____

Any surgeries? Yes No
Please list_____

Any accidents? Yes No If yes when? _____

Any MRI / CT / X-rays in the past year? Yes No
Please list_____

Back Pain Chiropractic
2006 N State Line Ave
Texarkana, AR 71854

Responsible Insurance

Name of Insured_____

Name of Insurance Company _____
Address_____
City, State, Zip_____Phone Number _____
Claim/Policy number_____
Adjuster_____

Employer Information

Employer_____
Occupation_____
Address_____ city-state, Zip_____
Phone number (_____)_____

I give full permission to Back Pain Chiropractic Clinic to use any information to release to my family doctor and any other treating doctors regarding my conditions.

Patient Signature_____ Date _____

Consent to treat a minor child
(Guardian information is needed if patient is a minor)

I hereby authorize Back Pain Chiropractic Clinic to administer treatment as they deem necessary to my child.

Guardian Name_____
Date of Birth_____ Social Security number_____
Address if different from patient_____
City, State, Zip_____ Phone number_____

Signature of Guardian_____ Date_____

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