Today's Date: _____/_____/_____

PATIENT INFORMATION

Legal First Name:_____ Middle Name:_____ Last Name:_____

Mailing Address:_____ Apt:_____ City:_____

State:_____ Zip Code:_____ Cell phone:_____ Home phone:_____

Email:_____ DOB:_____/_____/_____ Gender: ☐ **Male** ☐ **Female**

Marital Status: ☐ **Single** ☐ **Married** Spouse:_____
☐ **Widowed** ☐ **Divorced** ☐ **Separated**

SSN:_____-_____-_____ Primary Care Physician:_____

How did you hear about us?: ☐ **Internet search** ☐ **Facebook** ☐ **Phonebook** ☐**Physician**
☐ **Friend/Family** ☐ **Existing Patient** (Name:_____)
☐ **Walk-by** ☐ **Other**:_____

Occupation:_____ Employer:_____

Employer Address:_____

Emergency Contact:_____ Phone Number:_____

CURRENT SYMPTOMS & PATIENT HISTORY

Please list your areas of pain and any providers treating you for the condition/s:

_____

_____

When did your symptoms begin?: _____/_____/_____

Do you have any concerns with the following?:

☐ **Weight** ☐ **Nutrition** ☐ **Sleep** ☐ **Healthy aging** ☐ **Fitness**

PAST HEALTH HISTORY: Have you…

Been hospitalized in the last 5 years? ☐ **Y** ☐ **N** If yes, date and provider seen:_____

Been diagnosed with diabetes? ☐ **Y** ☐ **N** If yes, what type? ☐ **Type I** ☐ **Type II**

Vitals: Height:_____ Weight:_____

Do you smoke? ☐ Never ☐ Former Smoker ☐ Current Every Day Smoker ☐ Current Occasional Smoker

Do you have allergies? List type and reaction:_____

Medications: What medications are you currently taking?

_____

_____

HARBOR LIFE CHIROPRACTIC

ASSIGNMENT AND RELEASE

I understand and agree that health and accident insurance policies are an agreement between an insurance carrier and myself. Furthermore, I understand that this 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 this doctor's office will be credited to my account upon receipt. However, I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees or outstanding balances for services I have received will be immediately due and payable.

Patient or Guardian Signature: _____

Date: _____/_____/_____

CONSENT OF PROFESSIONAL SERVICES AND RELEASE OF INFORMATION

I hereby authorize and release the doctor and whomever he may designate as his assistants, to administer treatment, physical examination, x-ray studies, laboratory procedures, chiropractic care or any clinic services that he deems necessary in my case; I furthermore authorize him to disclose all or any part of my patient record to any person or corporation which is or may be liable under a contract to this office or to the patient or to a family member or employer of the patient for all or part of the clinic's charge, including, and not limited to hospital or medical service companies, insurance companies, worker's compensation carriers, welfare funds, or the patient's employer.

Patient or Guardian Signature: _____

Date: _____/_____/_____

COVERAGE INFORMATION

Please check one of the following:

☐ **Self-pay**

☐ **Medicare**

☐ **Insurance**

Primary Insurance Company: _____

Secondary Insurance Company (if any): _____

Please give any insurance cards to the receptionist to scan into your account.