Spring Lake Chiropractic

Patient Welcome Forms

1171 N. Bragg Blvd., Spring Lake, NC 28390

Phone: (910)436-5000 Fax:(910)436-7705

PATIENT INFORMATION

Today's Date: . . . .

Name: . . . .

Date of Birth: . . . .

Address: . . . . City: . . . .

State: . . . . Zip: . . . .

Home Phone: . . . . Cell Phone: . . . .

Social Security #: . . . . Age: . . . . ☐ Male ☐ Female Non-Binary

Email Address: . . . .

Marital Status ☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Other . . . .

Emergency Contact: . . . . Phone: . . . . Relationship: . . . .

Your Occupation: . . . . Your Employer: . . . .

Referred to this Office by: ☐ Friend/Family Member - Name . . . .
☐ Mail ☐ Clinic Location ☐ Other . . . .

Preferred language spoken: . . . .

Ethnicity: Hispanic or Latino/Mexican/African-American/White/Asian/Other: . . . .

Are you a smoker? . . . .

Payment Method: Insurance Company: . . . .

Subscriber ID: . . . . Group #: . . . .

Assignment and Release:

I certify that I, and/or my dependents have insurance coverage with ____________________________ and assign directly to Spring Lake Chiropractic all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I'm financially responsible for all charges whether or not pain by insurance. I authorize the use of my signature on all insurance submissions.

Spring Lake Chiropractic may use my health care information and may disclose such information to my insurance company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent ends when my current treatment plan is completed or for one year from the date below.

. . . .
Printed name of patient and/or guardian

. . . .
Signature of Patient and/or Guardian Date Relationship to Patient

FAMILY MEDICAL HISTORY:

S = Self M = Mother F = Father

(Please indicate which conditions have been experienced by the above by marking appropriate boxes)

S	M	F		S	M	F		S	M	F	
☐	☐	☐	AIDS	☐	☐	☐	Dislocated joints	☐	☐	☐	Neck pain
☐	☐	☐	Anemia	☐	☐	☐	Epilepsy	☐	☐	☐	Nervousness
☐	☐	☐	Arthritis	☐	☐	☐	German measles	☐	☐	☐	Numbness
☐	☐	☐	Asthma	☐	☐	☐	Headaches	☐	☐	☐	Polio
☐	☐	☐	Back pain	☐	☐	☐	Heart trouble	☐	☐	☐	Poor circulation
☐	☐	☐	Bladder trouble	☐	☐	☐	Reproductive disorders	☐	☐	☐	Hepatitis
☐	☐	☐	Bone fracture	☐	☐	☐	High blood pressure	☐	☐	☐	Rheumatic fever
☐	☐	☐	Cancer	☐	☐	☐	HIV / ARC	☐	☐	☐	Rheumatism
☐	☐	☐	Chest pain	☐	☐	☐	Kidney disorder	☐	☐	☐	Scarlet fever
☐	☐	☐	Concussion	☐	☐	☐	Bowel control loss	☐	☐	☐	Serious injury
☐	☐	☐	Convulsions	☐	☐	☐	Menstrual cramps	☐	☐	☐	Sinus trouble
☐	☐	☐	Diabetes	☐	☐	☐	Multiple sclerosis	☐	☐	☐	Tuberculosis
☐	☐	☐	Indigestion	☐	☐	☐	Muscular dystrophy	☐	☐	☐	Venereal disease

SURGICAL HISTORY

1. . . . . Date: . . . .

2. . . . . Date: . . . .

3. . . . . Date: . . . .

Have you ever had a metal implant? ☐ Yes ☐ No