Wiederrich Chiropractic Clinic
Confidential Patient Information Form

Name _____ **Date of Birth** _____ **Marital Status: M S W D**

Address _____ **City** _____ **Zip** _____

Email _____ **Mobile Phone (_____)** _____

Home Phone (_____) _____ **Work Phone (_____)** _____

Employer _____ **Occupation** _____

Name of spouse _____ **Spouse's Employer** _____

Emergency contact name & phone # _____

Relationship of emergency contact (Parent/ Other Relative/Friend) _____

Referred By (circle): Yellow Pages / Provider Manual / Other physician / Friend or relative

Name _____

Is your visit the result of an auto or work injury? (Circle) Yes/No If yes, which _____

Have you seen other doctors or chiropractors for this problem? (Circle) Yes/No If yes, who _____

_____

Have you had any x-rays, MRI or CT Scan of your spine? Circle: Yes / No

If yes, when and where were they taken? _____

_____

Additional information _____

PAYMENT IS EXPECTED AT THE TIME OF SERVICE

Are you insured? (Circle) Yes/No Insurance Company _____

Would you like us to send claims to your insurance? (Circle) Yes/No

I understand and agree that insurance policies are an arrangement between an insurance carrier and myself, and that I am personally responsible for payment for all services rendered me, regardless of any applicable insurance or benefit payments. Furthermore, I understand and agree that the Wiederrich Chiropractic Clinic will submit any necessary forms and/or reports to collect payment from the insurance carrier, and I authorize any applicable payment be made directly to the Wiederrich Chiropractic Clinic. Additionally, I hereby authorize the doctor to release all medical information necessary to process claims, and authorize the use of my signature below on all insurance claims submitted by the Wiederrich Chiropractic Clinic.

Patient's Signature: _____ **Date** _____

Guardian's Signature Authorizing Care: _____ **Date** _____

Confidential Health Information Form

Name: _____

Please check yes or no for all of the following. For yes answers, please circle the condition that applies to you.

Yes	No	Condition	Yes	No	Condition
☐	☐	History of Recent Infection / Fever	☐	☐	Anxiety, Depression, Hallucinations
☐	☐	Abnormal Weight ☐Gain ☐Loss	☐	☐	Easy Bruising/Bleeding
☐	☐	Eye Problems (double vision, blurry, etc.)	☐	☐	Excessive Thirst, Excessively Cold or Hot
☐	☐	Ear Problems (ringing, bleeding, etc.)	☐	☐	Frequent Infections
☐	☐	Nose, Mouth, Throat Problems	☐	☐	Skin Problems, Rashes
☐	☐	Chest Pain, Palpitations, Heart Murmurs	☐	☐	Osteoporosis
☐	☐	High Blood Pressure, Aneurysms or Stroke	☐	☐	Pregnancy, # of births _____
☐	☐	Dizziness/Fainting	☐	☐	Diabetes
☐	☐	Short of breath, Wheezing, Chronic Cough	☐	☐	Birth Control Pills
☐	☐	Heartburn, Vomitting, Diarrhea, Constipation	☐	☐	History of Low/Mid Back Pain
☐	☐	Urinary Urgency / Frequency, Infection	☐	☐	History of Neck Pain
☐	☐	Broken Bones, Torn Ligaments	☐	☐	History of Alcohol Use: # _____ day/wk
☐	☐	Cancer/Tumor	☐	☐	History of Tobacco Use: # _____ day/wk
☐	☐	Numbness/Tingling, Seizures, Epilepsy	☐	☐	Allergies: _____

Family History: ☐ None ☐ Cancer ☐ Diabetes ☐ Cardiovascular Problems / Stroke ☐ High Blood Pressure ☐ Adopted/Unknown

_____

Current Medications: _____

☐ None _____

Previous Surgeries: _____

☐ None _____

Current Work Activities: Sit more than stand—Stand more than sit—Sit/stand equally—Walking

Previous Auto / Work Injuries: None—Yes, describe _____

Previous Military Injuries: None—Yes, describe _____

Exercise Habits: None—Regular Program—Semi-regular program (Describe) _____

_____

I certify that the above information is complete and accurate. I agree to notify the doctor immediately whenever I have changes in my health condition or health plan coverage in the future.

Signature:_____ Date: _____

Doctors' Notes _____

_____

_____

_____ Doctors' Initials_____