Welcome

Texas Chiropractic & Rehab
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Patient Information

Date ______
SS/Patient ID# ______
Patient Name ______
Last Name
______
First Name Middle Initial
Sex [ ] M [ ] F Age ______
Birthdate ______
Email ______

Address ______
City ______
State ______ Zip ______
Home Phone ( ) ______
Cell Phone ( ) ______
[ ] Married [ ] Widowed [ ] Single [ ] Minor
[ ] Separated [ ] Divorced [ ] Partnered for Years

Occupation ______
Patient Employer/School ______

Employer/School Phone ______
Employer/School Address ______

Spouse's Name ______
Spouse's Birthdate ______
SS# ______

Spouse's Employer ______

Whom may we thank for referring you? ______

Insurance

Who is responsible for this account? ______
Relationship to Patient ______
Insurance Co. ______
Group # ______
Is patient covered by additional insurance: [ ] Yes [ ] No
Subscriber's Name ______
Birthdate ______ SS# ______
Relationship to Patient ______
Insurance Co ______
Group# ______

ASSIGNMENT AND RELEASE

I certify that I, and/or my dependent(s), have insurance coverage with ______ and assign directly to
Name of Insurance Company
Dr. ______ all insurance benefits, if any, otherwise payable to me for service rendered. I understand that financially responsible for all charges whether or not paid by insurance. I am authorize the use of my signature on all insureance submissions.

The above-named doctor may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and deterring insurance benefits or the benefits payable for related services. The consent will end when my current treatment plan is completed or one year from the date signed below.

______
Signature of Patient, Parent, Guardian or Personal Representative

______
Print name of Patient, Parent, Guardian or Personal Representative

______ ______
Date Relationship to Patient

Emergency Information

In case of emergency, contact:
Name ______

Relationship ______
Home Phone ( ) ______
Work Phone ( ) ______
Cell Phone ( ) ______

Accident Information

Is condition due to an accident? [ ] Yes [ ] No
Date ______
Type of accident [ ] Auto [ ] Work [ ] Home [ ] Other
To whom have you made a report of your accident?
[ ] Auto Insurance [ ] Employer [ ] Worker Comp. [ ] Other

Attorney Name (if applicable) ______

Patient Condition

Reason for your visit? ______
When did your symptoms appear? ______
Is this condition getting progressively worse? [ ] Yes [ ] No [ ] Unknown
Mark an X on the picture where you continue to have pain, numbness, or tingling.
Rate the severity of your pain on a scale from 1 (least pain) to 10 (severe pain) ______
Type of pain: [ ] Sharp [ ] Dull [ ] Throbbing [ ] Numbness [ ] Aching [ ] Burning
[ ] Shooting [ ] Cramps [ ] Tingling [ ] Swelling [ ] Stiffness [ ] Other ______
______
How often do you have this pain? ______
Is it constant or does it come and go? ______
Does it interfere with your [ ] Sleep [ ] Work [ ] Recreation [ ] Daily Routine
Activities that are painful to perform [ ] Sitting [ ] Standing [ ] Bending [ ] Walking [ ] Lying Down