Accident & Injury Chiropractic 1702 South 72nd Street Suite A Tacoma, WA 98408 P: (253) 474 – 0677 F: (253) 474 – 3540

PERSONAL HISTORY

Name: _____Date: _____/_____/_____

Address: _____ Apt. #: _____

City: _____ State: _____ Zip: _____

Cell#: (_____) _____ - _____ Home#: (_____) _____ - _____ Work#: (_____) _____ - _____

Date of Birth: _____/_____/_____ Age: _____ SS#: _____-_____-_____ Sex: □Male □Female

E-mail: _____ Driver's License #: _____

Occupation: _____ Employer: _____

Status: □ Married □ Single □ Domestic Partner □ Widowed □ Divorced □ Separated

Name of emergency contact: _____ Phone#: (_____) _____ - _____

FORM OF PAYMENT □ CASH □ CHECK (*Payable to Accident & Injury Chiropractic*) □ VISA / MC □ CARE CREDIT

Are you insured? □ YES □ NO

Primary Insurance: _____

Insured's Name: _____ Insured's Date of Birth: Date: _____/_____/_____

Insured's ID #: _____ Group #: _____

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that *Accident & Injury Chiropractic* will prepare any necessary forms and reports to assist me in making collection from the insurance company and that any amount authorized to be paid directly to *Accident & Injury Chiropractic* 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 I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered me will be immediately due and payable.

It is understood and agreed the amount paid the doctor, for x-rays, is for examination only and the x-ray negatives will remain the property of the office, and may be released with a written notification and 15 days notice.

Patient / *Guardian* Signature _____ Date _____/_____/_____

Printed Name _____

Relations to Minor (*If Guardian*) _____

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PAST HEALTH HISTORY

Name: _____Date: _____/_____/_____

Major Surgery/Operation(s): □ Back Surgery □ Broken Bones □ Neck Surgery

Other: _____

Major Accident(s) or Fall(s): _____

Hospitalization(s) (*Other than above*): _____

Name of your Medical Doctor: _____ Phone#: (_____) _____ - _____

Address: _____

Previous Chiropractic Care: □ None □ Yes –

Doctor's Name: _____

Approximate Date of last visit: _____/_____/_____

CURRENT HEALTH CONCERNS

Height: _____'_____" Current Weight: _____

My current health concerns are from: □ Auto Collision □ Work Injury □ Other: _____

Major Complaints:

A. _____ D. _____

B. _____ E. _____

C. _____ F. _____

Comments:

PLEASE OUTLINE ON THE DIAGRAM
THE AREAS OF YOUR DISCOMFORT