COX CHIROPRACTIC

W. JOHN COX, D.C.

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DATE_____

CONFIDENTIAL PATIENT ADMITTANCE FORM

PLEASE PRINT
FULL NAME_____ SPOUSE _____

ADDRESS_____
STREET CITY STATE ZIP

DATE OF BIRTH____/____/____ AGE_____ MARRIED____ SINGLE_____ PREGNANT?_____

PHONE_____CELL #_____ HT._____ WT._____

EMPLOYER'S NAME AND PHONE_____

SPOUSE'S WORK/ CELL PHONE _____.

E-MAIL ADDRESS_____

EMERGENCY CONTACT _____
NAME PHONE

WHOM MAY WE THANK FOR REFERRING YOU? _____

HAVE YOU BEEN TO A CHIROPRACTOR BEFORE? _____

NAME_____DIAGNOSIS_____

LIST MEDICAL DOCTORS CONSULTED WITHIN THE PAST YEAR:

NAME_____DIAGNOSIS_____

PRESENT FAMILY DOCTOR_____ CITY_____

DATE OF LAST PHYSICAL EXAM_____BY WHOM_____

LIST YOUR SYMPTOMS:	HOW LONG?	HAD CONDITION BEFORE?
1). _____	_____	_____
2). _____	_____	_____
3). _____	_____	_____

LIST ADDITIONAL SYMPTOMS ON BACK OF PAGE

ACCIDENTS AND/OR INJURIES RELATED TO CURRENT SYMPTOMS:

	DATE:	HOSPITALIZED?
1)		

(If current accident or injury is going to be covered under a workman's comp. or personal injury insurance plan, please request an office insurance information form from the receptionist.)

PAST HISTORY OF ACCIDENTS OR INJURIES:

	DATE:	HOSPITALIZED?
1)		
2)		

LIST ADDITIONAL ON BACK

SURGERY:

	DATE:	HOSPITALIZED?
1)		
2)		

LIST ADDITIONAL ON BACK

CHECK THE FOLLOWING CONDITIONS YOU HAVE NOW OR HAVE HAD:

___ Alchoholism	___ Constipation	___ Goiter	___ Irregularity	___ Pneumonia
___ Allergy	___ Cold Sores	___ Gout	___ Miscarriage	___ Stroke
___ Anemia	___ Diabetes	___ High Bld. Pressure	___ Multiple Sclerosis	___ Thyroid Problem
___ Arteriosclerosis	___ Diarrhea	___ Heart Attack	___ Neuritis	___ Ulcers
___ Arthritis	___ Convulsions	___ Heart Disease	___ Nervousness	___ Gall Bladder
___ Backaches	___ Emphysema	___ Headaches	___ Depression	___ Whooping Cough
___ Cancer	___ Epilepsy	___ Low Bld. Sugar	___ Pleurisy	___ Menstrual Cramps

LIST MEDICATIONS AND/OR DIET SUPPLEMENTS YOU ARE PRESENTLY TAKING:

	Medication or Supplement	Frequency and Strength	Doctor
1)			
2)			
3)			

I UNDERSTAND AND AGREE THAT ALL SERVICES RENDERED ME ARE CHARGED DIRECTLY TO ME AND THAT I AM PERSONALLY RESPONSIBLE FOR PAYMENT. IN THE CASE OF COVERAGE INVOLVING WORKMAN'S COMPENSATION OR A PERSONAL INJURY CASE, PAYMENT WILL NOT BE MADE BY THE PATIENT BUT BY THE INSURANCE CARRIER.

SIGNATURE OF PATIENT OR GUARDIAN_____

The only way we can continue to minimize the cost of your Chiropractic care is to request payment in full at the completion of each office visit. For your convenience, Visa, Discover, and MasterCard are accepted. You will receive an itemized receipt after each office visit that should contain all the information your insurance carrier will need from our office to process your claim.

In special circumstances, other arrangements will always be made to accommodate your health care needs regardless of your ability to pay. Simply talk to the Doctor.