caminez CHIROPRACTIC
FOCUSED ON YOUR WELLNESS

NEW PATIENT APPLICATION FOR CARE

Welcome to our practice! Please thoroughly complete all questions. All information Is Confidential.

Name: _____ Referred by: _____

Address: _____ City: _____ State: _____ Zip: _____

Date of Birth: _____ Age: _____ Marital Status: _____ # of Children: _____ SS#:_____

Home Phone: _____ Cell Phone: _____ Email: _____

Occupation: _____ Employer:_____ Work Phone: _____

Emergency Contact :_____Relationship:_____ Emergency Contact Phone:_____

Do you have insurance? Yes or No **(If yes, please give the front desk your card to copy)** Are you the primary cardholder? Yes or No

Name of Insurance Company: _____

(If no), Name of primary cardholder_____ Date of Birth_____

Method of payment for first visit: Cash _____ Check _____ Credit Card_____

Health reasons for consulting our office: _____

Date of Onset? _____ _____

Have you had this condition before? _____ If yes, when? _____

Is this a result of an auto or work injury:_____ Date of Accident: _____ Have you lost days form work?_____

What other doctors have you seen for this condition?_____

Mother/Father/Brother/Sister/Children with similar problems?_____

List medications you now take (prescription & non-prescription):_____

Please mark X for present conditions, O for past conditions

_____ Fractured Bones	_____ Shoulder Pain R L	_____ Frequent Colds/Flu	_____ Difficulty Breathing
_____ Auto Accidents	_____ Mid-Back Pain/Stiffness	_____ Cancer –Type_____	_____ Trouble Sleeping
___ 0-1 years ago	_____ Hip Pain R L	_____ Blurred Vision R L	_____ Stroke
___ 1-5 years ago	_____ Low Back Pain/Stiffness	_____ Trouble Concentrating	_____ Allergies
___ More than 5	_____ Numbness, Tingling or Pain	_____ Hearing Loss R L	_____ Digestive Problems
_____ Pain/Stiff Neck R L	Buttocks, Thighs, Legs, Feet, Toes R L	_____ Arthritis	_____ Jaw Pain/TMJ R L
_____ Numbness/Tingling/Pain	_____ Foot/Ankle Pain R L	_____ Sinus Problems	_____ Asthma
Arms/Hands/Fingers/Wrists R L	_____ High/Low Blood Pressure	_____ Dizziness	_____ Convulsions/Epilepsy

****The above information is true and accurate to the best of my knowledge. My reason for consultation with the Doctor is for evaluation of my physical health and the potential for improvement.***

Patient *or* Guardian Signature: _____ Date: ___ / ___ /___

Pregnancy release (Please sign if you are NOT pregnant):

This is to certify that to the best of my knowledge I am **not** pregnant and the doctor and his/her associates have my permission to perform an x-ray evaluation. I have been advised that x-ray can be hazardous to an unborn child.

_____ _____

(Signature) *(Date)*