Patient Information

Full Name_____

Address_____

_____

City State Zip

Sex ☐ Male ☐ Female Age_____

Birthdate:_____

Social Security Number_____

Primary Medical Physician & Clinic: _____

_____

Occupation_____

Employer_____

Employer Address_____

Spouse's Name_____DOB_____

Spouse's Employer_____

Whom May we Thank for Referring

You?_____

Phone Number

Cell_____Work_____

Email:_____

IN CASE OF EMERGENCY CONTACT:

Name_____

Relationship_____

Home Phone_____

Insurance Information

Who is responsible for this

account?_____

Relationship to Patient_____

Insurance Co._____

Group Number_____

Is patient covered by additional insurance? ☐Y ☐N

Assignment and Release

I, the undersigned certify that I (or my dependent) have insurance coverage with _____ _____and assign directly to Dr. Hoffman all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submission

**_____

Responsible Party Signature Date

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**

Patient Condition

Purpose for Visit (Wellness or Symptom)_____

Date symptoms appearing?_____Is this condition getting progressively worse? ☐ Yes ☐ No

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 ☐ Stiffness ☐ Burning

How often do you have this pain?_____Is it constant or does it come and go?_____

Current Medications and for what condition:_____

_____Does it interfere with your ☐ Work ☐ Sleep ☐ Daily Routine ☐ Recreation

Activities or movements that are painful to perform ☐Sitting ☐Standing ☐Walking ☐Bending ☐Lying Down

Have you ever received Chiropractic care? ☐ Yes ☐ No If yes, please list doctor's name, date, location of office and for what problems:_____