ANNAPOLIS FAMILY CHIROPRACTIC
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PERSONAL INFORMATION

LAST NAME:_____ FIRST NAME:_____ MIDDLE INITIAL:_____ SUFFIX:_____

NICKNAME:_____ SALUTATION: MR MRS MS MISS DR

ADDRESS:_____ HOME PHONE:_____ DATE OF BIRTH:_____/_____/_____

_____ WORK PHONE:_____ GENDER: MALE FEMALE

_____ CELL PHONE:_____ SOCIAL SECURITY:_____

MARITAL STATUS: SINGLE MARRIED LEGALLY SEPARATED DIVORCED WIDOWED

REFERRED BY:_____

IF EMPLOYED: FULL-TIME PART-TIME

EMPLOYER NAME:_____ OCCUPATION:_____

EMPLOYER'S ADDRESS:_____

IF A STUDENT: FULL-TIME PART-TIME

NAME OF SCHOOL ATTENDING:_____

PRIMARY CARE PHYSICIAN NAME (if different than "Referred by"):_____

IF UNDER 18 YEARS OF AGE, RESPONSIBLE PARTY'S NAME:_____

RESPONSIBLE PARTY'S RELATION TO PATIENT:_____

RESPONSIBLE PARTY'S ADDRESS (if different than patient):_____

RESPONSIBLE PARTY'S PHONE NUMBER (if different than patient home phone):_____

INSURANCE INFORMATION

PRIMARY INSURANCE: INSURANCE COMPANY:_____

ID#:_____ GROUP:_____

INSURED'S NAME (if different than patient):_____ RELATIONSHIP TO INSURED: SELF SPOUSE CHILD

INSURED'S SSN (if different than patient):_____ BIRTH DATE:_____/_____/_____ GENDER: MALE FEMALE

INSURED'S EMPLOYER (if different than patient):_____

SECONDARY INSURANCE: INSURANCE COMPANY:_____

ID#:_____ GROUP:_____

INSURED'S NAME (if different than patient):_____ RELATIONSHIP TO INSURED: SELF SPOUSE CHILD

INSURED'S SSN (if different than patient):_____ BIRTH DATE:_____/_____/_____ GENDER: MALE FEMALE

INSURED'S EMPLOYER (if different than patient):_____

(OVER)

INJURY INFORMATION

ARE YOUR PRESENT PROBLEMS DUE TO AN INJURY? YES NO

IF YES, WAS IT: ON THE JOB AN AUTO ACCIDENT A PERSONAL INJURY OTHER

IF YOU WERE INVOLVED IN AN AUTO ACCIDENT, HAS THE ACCIDENT BEEN REPORTED? YES NO

HAS THE ACCIDENT CAUSED YOU TO BE DISABLED? YES NO

DISABILITY DATES: _____ TO _____

HAVE YOU RETAINED AN ATTORNEY? YES NO

IF YES, NAME, ADDRESS, AND PHONE NUMBER OF ATTORNEY:_____

_____

- I ATTEST THAT ALL THE INFORMATION GIVEN HEREWITH IS TRUE AND CORRECT.
- I AGREE TO NOTIFY ANNAPOLIS FAMILY CHIROPRACTIC OF ANY CHANGE IN THIS INFORMATION.
- I AUTHORIZE RELEASE OF MY MEDICAL RECORDS AND/OR INFORMATION REGARDING MY TREATMENT TO MY PRIMARY CARE OR REFERRING PHYSICIAN(S), AND/OR SPECIALIST PROVIDER TO WHICH ANNAPOLIS FAMILY CHIROPRACTIC MAY REFER ME. I FUTHER ACKNOWLEDGE THAT A COPY OF THIS RELEASE CAN BE USED IN PLACE OF THE ORIGINAL.

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PATIENT OR LEGAL GUARDIAN SIGNATURE DATE