WELCOME TO DALLAS CHIROPRACTIC

NAME_____

DATE OF BIRTH_____ CIRCLE ONE PLEASE: FEMALE MALE

CIRCLE ONE PLEASE: SINGLE MARRIED DIVORCED WIDOWED

EMAIL: _____

STREET
ADDRESS_____

CITY:_____STATE:_____ZIP:_____PHONE:_____

EMPLOYER: _____

EMPLOYER'S
ADDRESS_____

OCCUPATION_____HOW LONG? _____

WORK PHONE_____

REFERRED BY_____

EMERGENCY CONTACT: _____

RELATION_____ PHONE_____

MEDICAL HISTORY:

PLEASE LIST ANY SERIOUS MEDICAL CONDITION YOU HAVE OR EVER HAD:

HAVE YOU RECEIVED ANY COVID VACCINES? YES NO

HOW MANY? _____ WHAT TYPE? _____

ALLERGIES: _____

SMOKER: YES NO HOW MUCH AND HOW LONG? _____

PLEASE LIST SURGERIES WITH DATES: _____

DO YOU WEAR ORTHOTICS? _____ AGE OF MATTRESS? _____

WOMEN: DO YOU TAKE BIRTH CONTROL? ___ PREGNANT? ____ NURSING? __

Y N	HEART ATTACK/STROKE	Y N	HEART SURG/PACEMAKER
Y N	CONGENITAL HEART DEFECT	Y N	MITRAL VALVE PROLAPSE
Y N	ALCOHOL/DRUG ABUSE	Y N	VENEREAL DISEASE
Y N	HIV/AIDS	Y N	SHINGLES
Y N	FREQUENT NECK PAIN	Y N	EMPHYSEMA/GLAUCOMA
Y N	HIGH/LOW BLOOD PRESSURE	Y N	PSYCHIATRIC PROBLEMS
Y N	SEVERE/FREQUENT HEADACHES	Y N	KIDNEY PROBLEMS
Y N	FAINTING/SEIZURES/EPILEPSY	Y N	SINUS PROBLEMS
Y N	DIABETES/TUBERCULOSIS	Y N	DIFFCULTY BREATHING
Y N	LOWER BACK PROBLEMS	Y N	ARTIFICIAL BONES/JOINTS
Y N	HEART MURMUR	Y N	RHEUMATIC FEVER
Y N	ULCERS/COLITIS	Y N	ARTIFICIAL VALVES
Y N	ASTHMA	Y N	HEPATITIS
Y N	CHEMOTHERAPY	Y N	CANCER
Y N	ARTHRITIS	Y N	ANEMIA

OUR OFFICE POLICY REQUIRES PAYMENT IN FULL FOR ALL SERVICES RENDERED AT THE TIME OF VISIT. IF YOUR ACCOUNT IS NOT PAID WITHIN 90 DAYS OF DATE OF SERVICE, YOU WILL BE RESPONSIBLE FOR ANY EXPENSES INCURRED IN COLLECTING YOUR ACCOUNT. I HEREBY AUTHORIZE PAYMENT OF BENEFITS DIRECTLY TO THE PROVIDER FOR SERVICES RENDERED. I FURTHER AUTHORIZE THE PROVIDER TO RELEASE ANY INFORMATION REQUIRED TO PROCESS INSURANCE CLAIMS. I UNDERSTAND THE ABOVE INFORMATION AND GUARANTEE THIS FORM WAS COMPLETED CORRECTLY AND IT IS MY REPONSIBILITY TO INFORM YOUR OFFICE OF MEDICAL CHANGES.

SIGNATURE OF RESPONSIBLE PERSON_____