STANFIELD
CHIROPRACTIC

New Patient Form

905 Remington Rd. | Mattoon, IL 61938
Ph: 217-234-3423 | F: 217-234-3892

Date: _____

PATIENT INFORMATION

Patient Name: _____ DOB: _____

Prefer to be called: _____ Male / Female Minor / Single / Married / Divorced / Widowed .

Address: _____ SSN: _____

City: _____ State: _____ Zip: _____

Home Ph#: (_____) _____ Cell Ph#: (_____) _____

Medical Doctor: _____ Ph#: (_____) _____

EMPLOYER INFORMATION

Employer Name: _____ Supervisor: _____

Address: _____

City: _____ State: _____ Zip: _____

Insurance: _____

Adjuster Name: _____ Ph#: (_____) _____

HEALTH INSURANCE INFORMATION

Insurance Co: _____ Policy #: _____

Address: _____ Group #: _____

City: _____ State: _____ Zip: _____

Ph#: (_____) _____

Insured's Name: _____ DOB: _____

Relationship: _____

_____: I authorize assignment of my insurance rights and benefits to the provider for services rendered. I understand that I am solely responsible for balance not paid by my insurance company.
(initial)

Insured's Employer: _____

Insured's Employer Address: _____

City: _____ State: _____ Zip: _____

IN EVENT OF AN EMERGENCY

Contact Name: _____ Relationship: _____

Home Ph#: (_____) _____ Cell Ph#: (_____) _____

Our office policy requires payment at the time services are rendered, unless other arrangements are made. The patient is responsible for legal/collection agency fees, as well as interest charges or other expenses if the balance remains unpaid past 90 days of the last treatment. The staff and provider are authorized to perform necessary services during diagnosis and treatment, and to release the information needed to process claims through insurance.

By signing below, I acknowledge that I have received a copy of the Summary of Privacy Notice. I also understand the information stated above. The information provided is the most current and accurate to my knowledge. It is my responsibility to update this office of any changes.

Signature: _____ Date: _____

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Patient Name: _____ Date: _____

REASON FOR VISIT

Reason for today's visit: ☐ Emergency ☐ New injury ☐ Chronic Pain ☐ Wellness

Are you in pain? _____ If yes, rate your pain: 0 – 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10

Is this injury the result of: ☐ Auto Accident ☐ Work ☐ Routine/Household activity ☐ Play/Sports

When did the accident/injury happen? ____/____/_____ Where did your injury occur? _____

Explain what happened in your own words: _____

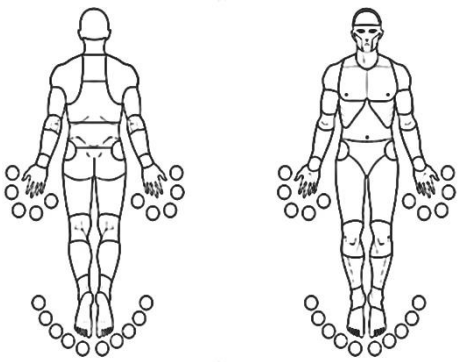
_____

Is your condition: ☐ Getting worse ☐ Constant ☐ Comes and goes

Is your condition interfering with your: ☐ Work ☐ Sleep ☐ Routine

If so, how? _____

PLEASE CIRCLE THE AREAS YOU ARE HAVING TROUBLE WITH ON THE DIAGRAM >>



Has a similar incident ever happened before?

If so, please explain: _____

Have you been treated by a medical physician for this condition?

☐ Yes ☐ No Where?:_____

Have you ever been treated by a Chiropractor?

☐ Yes ☐ No Clinic Name: _____

Ph#: (_____) _____

HEALTH HISTORY

Are you taking any of the following medications?
☐ Nerve pills ☐ Pain killers ☐ Muscle relaxers ☐ Blood thinners ☐ Tranquilizers ☐ Insulin ☐ Other _____

Do you have or have you had any of the following diseases, medical conditions of procedures? Please circle

Heart attack/stroke	Fainting/seizures/epilepsy	Glaucoma
Artificial valves	Chemotherapy	Sever/frequent headaches
Shingsles	Heart murmur	Emphysema/asthma
High/low blood pressure	Vereal disease	Artificial bones/joints/implants
Ulcers/colitis	Frequent neck pain	Mitral valve prolapse
Difficulty breathing	Rheumatic fever	HIV+/AIDS/ARC
Heart surg./pacemaker	Sinus problems	Anemia/Diabetes
Alcohol/drug abuse	Lower back problems	Kidney problems
Cancer	Congenital heart defect	Tuberculosis
Psychiatric problems	Hepatitis	Arthritis

List Surgeries with dates: _____

Allergies: _____

Family Health History: _____

Do you take supplements/vitamins: _____ Do you smoke? _____

Do you exercise? _____ Are you pregnant? _____ Wks:_____