ROY MURRELL, DC

New Patient Form

ABOUT YOU

Today's date

Patient name:

What you prefer to be called

M F Age

Birthday

Mailing address

Home Phone

Work Phone

Mobile Phone

E-mail address

Referred by

Employer

Occupation

Status *minor single married divorced separated widowed*

Spouse's name

Do you have children? Y N How many?

REASON FOR YOUR VISIT

Primary concern:

Please describe the pain and its location:

Have you had this or similar conditions in the past?

Y N If so, please explain:

Have you been treated by a Medical Physician for this condition?

Y N If so, where?

Have you ever been treated by a Chiropractor before?

Y N If so, whom?

INSURANCE INFORMATION

Company name

Address City State Zip Phone

Insured's ID# Group # Plan (*Local or Policy No.*)

Insured's Name

Relation Date of Birth

In the event of emergency

Whom should we contact?

Relation

Home ph: Work ph: Mobile

Your Medical Doctor Phone

Are you taking any of the following medications?

Nerve pills ◯ Pain killers (including aspirin) ◯ Muscle relaxers ◯ Stimulants ◯

Blood Thinners ◯ Tranquilizers ◯ Insulin ◯ Other(s) ◯

Heart Attack / Stroke Heart	◯	*Artificial Valves*	◯
Heart Surgery/Pacemaker	◯	*Alcohol / Drug Abuse*	◯
Heart Murmur	◯	*Artificial Bones/Joints*	◯
Congenital Heart Defect	◯	*Hepatitis*	◯
Mitral Valve Prolapse	◯	*Shingles*	◯
Cancer	◯	*High/Low Blood Pressure*	◯
Frequent Neck Pain	◯	*Psychiatric Problems*	◯
Emphysema	◯	*Rheumatic Fever*	◯
Glaucoma	◯	*Severe/Frequent Headaches*	◯
Anemia	◯	*Kidney Problems*	◯
Ulcers/Colitis	◯	*Tuberculosis*	◯
Fainting/Seizures/Epilepsy	◯	*Difficulty breathing/Asthma*	◯
Sinus Problems	◯	*Chemotherapy*	◯
Diabetes	◯	*Lower back problems*	◯
Arthritis	◯	*Other:*	◯

List previous surgeries/treatments with approximate dates:

List any **past** serious accidents with dates:

Do you take supplements or vitamins? ◯ Do you exercise? ◯ Are you on a special diet? ◯

Do you smoke? ◯ How much? ◯ How long? ◯ Are you wearing: Heel lifts ◯ Sole lifts ◯ Inner soles ◯ Arch supports ◯

WOMEN: Are you taking Birth Control? ◯ Are you pregnant? ◯ Nursing? ◯

I invite you to discuss with me any questions regarding my services. The best health services are based on a friendly, mutual understanding between provider and patient. My policy requires payment in full for all services rendered at the time of visit unless other arrangements have been made with me. If your account is not paid within 90 days of the date of service and no financial arrangements have been made, you will be responsible for legal fees, collection agency fees, and any other expenses incurred in collecting your account.

I authorize any necessary services needed during diagnosis and treatment. I also authorize the provider and or managed care organization to release any information required to process insurance claims. I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes to the information I have provided.

Patient Signature *(or parent signature if a minor)* Date

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