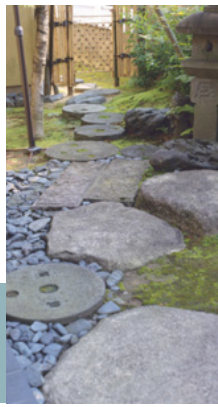


ROY MURRELL, DC

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

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