Danielle D. Sager, D.C.
Doctor of Chiropractic

Family Friendly Chiropractic

Improving your life one vertebra at a time

CONFIDENTIAL PATIENT INFORMATION

Date:______________________ Email:______________________________
Who referred you to this clinic?____
Is your visit due to an accident? [ ] Yes [ ] No If "Yes" please give a brief explanation: _______________
____

PATIENT DATA

Name________________________________ Home Ph________________ Work Ph______________ Cell Ph____________
Address____ City____________________________ Zip_________________
Age________ Birth Date_____________ Marital Status____________________ Number of children_______________
Occupation_____________________________ Employer__________________________________ SS#__________________
Name of spouse____ Phone number___________________________
Birth Date ____________Occupation_________________________________ Employer____________________________
Nearest relative____ Phone number___________________________

PRESENT COMPLAINT

Briefly describe your symptoms: ____
____
Other doctors seen for this condition: ____
Address/phone #: ____

MEDICAL HISTORY

[ ] Cancer	[ ] Muscular Dystrophy	[ ] Rheumatic Fever	[ ] Polio
[ ] Multiple Sclerosis	[ ] Scarlet Fever	[ ] Tuberculosis	[ ] Epilepsy
[ ] Convulsions	[ ] Nervousness	[ ] High Blood Pressure	[ ] Asthma
[ ] Heart Trouble	[ ] Concussion	[ ] Digestive Disorders	[ ] Diabetes
[ ] Dizziness	[ ] Sinus Trouble	[ ] Hepatitis	[ ] Arthritis
[ ] Backaches	[ ] German Measles	[ ] Neuritis	[ ] Numbness
[ ] Venereal Disease	[ ] Rheumatism	[ ] Anemia	[ ] Surgery

If you have been treated by a physician for any health condition in the last year, please describe: _________
____ Date of last physical exam: ____________
Allergic to any medication? [ ] Yes [ ] No If "yes", please specify: _____________________________
Taking any medications? [ ] Yes [ ] No If "yes", please specify: _____________________________
Past pregnancies? ______ Past births? ______ Currently pregnant? [ ] Yes [ ] No LMP? ________________

INSURANCE INFORMATION

Insurance? [ ] Yes [ ] No Name of Insured____________________________ SS #_________________ DOB _________
Insurance company_______________________________ Phone # ____________________________________
Policy # _________________________ Group # _______________________ Membership # __________________________

TREATMENT CONSENT, MEDICAL RELEASE AUTHORIZATION AND ASSIGNMENT OF BENEFITS

--I consent to and authorized the administration of all diagnostic and therapeutic treatments that may be considered necessary in the judgment of the attending physician.
--I authorize the attending physician to furnish the above insurance carriers information regarding history, physical findings and treatment rendered.
--I authorize payments of benefits directly to the provider for the services rendered. I agree that I am responsible for any charges accrued in this office if my insurance coverage does not provide full benefits.

____ ____________________ ______________________
Patient's signature (or parent, if pt a minor) Date Witness