LUTZ CHIROPRACTIC, S.C.

PATIENT INFORMATION SHEET

Date _____
Name _____ Date of Birth _____
Address _____City_____Zip code _____
Home Phone _____ Cell Phone _____
Email _____
Please indicate preferred method of contact _____
Marital Status: ____ Single
____ Married
____ Divorced
____ Widowed

Race _____(White, Asian, African American, etc.)
Ethnicity: ___ Hispanic ____ Non-Hispanic
Preferred language: _____
Height _____ Weight _____ Blood Pressure _____

Smoking Status: ____ Current Smoker
____ Former Smoker
____ Never smoked

Alcohol Use: ____ Rare
____ Occasional
____ Often
How much _____

Medical History:
Operations _____
_____
Serious Injuries _____
_____
Current Medications _____
_____
_____
Allergies _____
_____

Have you ever had any of the following conditions:

___ Diabetes	___ Lung Disease
___ Hypertension	___ Gallbladder Dysfunction
___ Cancer	___ Thyroid (Hypo or Hyper)
___ Heart Disease	___ Asthma
___ Kidney Disease	___ Other (specify)

Family History: Has anyone in your family had any of the following?
Specify (M) Mother, (F) Father, (S) Sibling

___ Diabetes	___ Lung Disease
___ Hypertension	___ Gallbladder Dysfunction
___ Cancer	___ Thyroid (Hypo or Hyper)
___ Heart Disease	___ Asthma
___ Kidney Disease	___ Other (specify)

Current Chief Complaint _____

_____

Date of onset _____

Is this due to an employment Injury? Yes ___ No ___

If yes, name of employer _____

Employer phone and contact _____

Is this due to a motor vehicle accident? Yes ___ No ___

Do you have health insurance? Yes ___ No ___
(If yes, please provide a copy of the card.)

Who referred you to us for care? _____

Remarks: _____

I hereby state that the information on both sides of this form is true and correct. I authorize Lutz Chiropractic, S.C. to examine, take x-rays, treat, and do whatever is necessary in accordance with the state statutes for the care and management of my condition. I understand and agree that health and accident insurance policies are an arrangement between the insurance carrier and myself. Furthermore, I understand that Lutz Chiropractic, S.C. will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to Lutz Chiropractic. S.C. will be credited to my account upon receipt. I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment . Payment is expected at time of visit unless other arrangements have been made.

Patient Signature _____ Date _____

If under 18, parent or guardian _____