

CONFIDENTIAL PATIENT INFORMATION

Drake Chiropractic ~ 154 S. Rock Road, Wichita, Ks 67207 ~ Ph: 316.651.0156

Date: _____

PATIENT DATA

Name: First: _____ M.I.: _____ Last: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone: Home: _____ Work: _____ Cell: _____

Email Address: _____ Age: _____ Date of Birth: _____

SS#: _____ Marital Status: _____ Number of Children: _____

Occupation: _____ Employer: _____

Name of Spouse: _____ SS#: _____ Occupation: _____

Spouse's Employer: _____ Phone#: _____

PRESENT COMPLAINT

Briefly describe symptoms: _____

List other doctor(s) seen for this condition: _____

Are you pregnant? _____ Date of last menstrual period: _____

Do you have a pacemaker? _____

INSURANCE DATA

Insurance Company: _____ Phone#: _____

Insured's Name: _____ SS#/ID#: _____

Group Name: _____ Group#: _____

I clearly understand and agree that all services rendered me are charged directly to me and that I am responsible for payment. I authorize payment of medical benefits to Advanced Medical Associates, P.A. dba Drake Chiropractic Clinic and give my permission to this office to endorse co-issued remittances for the conveyance of credit to my account. I also authorize the release of any information necessary to process my claims.

Patient's Signature: _____ Date: _____

Spouse's or Guardian's Signature: _____ Date: _____