



DETTWILER CHIROPRACTIC
 9865 E. 116th Street, Suite 150
 Fishers, IN 46037
 (317) 841-1209

Patient Name _____
 Date _____
 Chart # _____

CONFIDENTIAL PATIENT INFORMATION

Name _____ Social Security # _____

Address _____ City _____ State _____ Zip Code _____

Home Phone _____ Cell Phone _____

Age _____ Birth Date _____ Marital Status Married Single Widowed Divorced No. of Children _____

Occupation _____ Employer _____

Address _____ Office Phone _____

Email Address _____ Do we have your permission to send you emails? YES NO

Name of Spouse _____ Spouse's Occupation _____

Spouse's Employer _____ Spouse's Office Phone _____

Patient's Nearest Relative _____ Relative's Home Phone _____

How did you hear about our office? _____

Emergency Contact _____ Phone _____

Date of Last Physical Examination _____ Medical Doctor's Name _____

Have You Ever Suffered From:

	YES	NO		YES	NO		YES	NO
1. Dizziness	<input type="checkbox"/>	<input type="checkbox"/>	8. Asthma	<input type="checkbox"/>	<input type="checkbox"/>	15. Female: Is there a chance you could be pregnant?	<input type="checkbox"/>	<input type="checkbox"/>
2. Backaches	<input type="checkbox"/>	<input type="checkbox"/>	9. Neuritis	<input type="checkbox"/>	<input type="checkbox"/>			
3. Heart Trouble	<input type="checkbox"/>	<input type="checkbox"/>	10. Digestive Disorders	<input type="checkbox"/>	<input type="checkbox"/>			
4. Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	11. Nervousness	<input type="checkbox"/>	<input type="checkbox"/>			
5. Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>	12. Sinus Trouble	<input type="checkbox"/>	<input type="checkbox"/>			
6. Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	13. Anemia	<input type="checkbox"/>	<input type="checkbox"/>			
7. Headaches	<input type="checkbox"/>	<input type="checkbox"/>	14. Cancer	<input type="checkbox"/>	<input type="checkbox"/>			

Reason for this Appointment _____

Other Doctors seen for this Condition _____

Has a physician treated you for any health condition in the last year? YES NO

If so, please describe _____

Remarks and additional information _____

PAYMENT IS EXPECTED AT THE TIME OF THE VISIT!

Will you be paying today by Cash Check Credit Card

Name of Person Responsible for Payment _____

Are you Insured Yes NO Company _____ Policy # _____

I authorize payment of medical benefits to DETTWILER CHIROPRACTIC for the services described on the insurance form. This authorization is to apply to all dates of service until it is revoked in writing. I agree to pay for services not covered by insurance and understand that I am ultimately responsible for payment in full at this office. I understand that Dettwiler Chiropractic may call to verify my insurance benefits as a courtesy, but I should also contact my insurance company to better understand my coverage.

Patient's Signature _____ Date _____

Guardian or Spouse's Signature _____ Date _____

Information Taken By _____ Date _____

PLEASE COMPLETE THE FOLLOWING QUESTIONS IF YOURS IS AN ACCIDENTAL INJURY

Date of Accident _____ Hour _____ AM ___ PM ___ Location _____

How did the Accident Occur? Auto Collision On-the-Job Injury Other _____

If on-the-job injury, how did it happen? (Please be specific) _____

What is your Job Title/Duties? _____

Did you report the injury to your foreman or employer? YES NO

Did you tell them you were coming to our office? YES NO

If auto accident, were you Driver Passenger Pedestrian

If auto collision, were you struck from Behind Right Side Left Side Front Auto was parked

Did your car strike the other(s) involved? YES NO Undetermined

Did the other car(s) strike yours? YES NO Undetermined

As a result of the accident, were traffic citations issued to you? YES NO

Were traffic citations issued to the other driver(s)? YES NO

Please list the extent of your known injuries _____

Did you require post-accident hospitalization? YES NO

Please check the symptoms below that you noticed since your accident

- | | | | |
|--|---|--|--|
| <input type="checkbox"/> Headache | <input type="checkbox"/> Dizziness | <input type="checkbox"/> Eyes Sensitive to Light | <input type="checkbox"/> Diarrhea |
| <input type="checkbox"/> Neck Pain | <input type="checkbox"/> Head Seems too Heavy | <input type="checkbox"/> Loss of Memory | <input type="checkbox"/> Cold Feet |
| <input type="checkbox"/> Neck Stiffness | <input type="checkbox"/> Pins and Needles in Arms | <input type="checkbox"/> Ringing in Ears | <input type="checkbox"/> Cold Hands |
| <input type="checkbox"/> Problems Sleeping | <input type="checkbox"/> Pins and Needles in Legs | <input type="checkbox"/> Flushed Face | <input type="checkbox"/> Upset Stomach |
| <input type="checkbox"/> Back Pain | <input type="checkbox"/> Numbness in Fingers | <input type="checkbox"/> Buzzing in Ears | <input type="checkbox"/> Constipation |
| <input type="checkbox"/> Nervousness | <input type="checkbox"/> Numbness in Toes | <input type="checkbox"/> Loss of Balance | <input type="checkbox"/> Cold Sweats |
| <input type="checkbox"/> Tension | <input type="checkbox"/> Shortness of Breath | <input type="checkbox"/> Fainting | <input type="checkbox"/> Fever |
| <input type="checkbox"/> Irritability | <input type="checkbox"/> Fatigue | <input type="checkbox"/> Loss of Smell | <input type="checkbox"/> Other |
| <input type="checkbox"/> Chest Pain | <input type="checkbox"/> Depression | <input type="checkbox"/> Loss of Taste | |

Have you missed any days of work? YES NO Dates _____

Insurance Companies Involved (auto accidents only)

Your Insurance Company _____

Insurance Company of person responsible for injuries _____

Have you been contacted by an insurance adjuster or company representative regarding this claim? YES NO

Do you have an attorney that has advised you in this case? YES NO

Patient's Signature _____ Date _____

Guardian or Spouse's Signature _____ Date _____

Information Taken By _____ Date _____