Welcome

Confidential Patient Information

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

Sex:_____ Martial Status:_____ D.O.B.:_____ Age:_____ Home Phone:_____
M or F Mo/Day/Year Area Code/Number

Mailing Address:_____ City:_____ State:_____ Zip Code:_____
Include street type such as St., Ave., etc.

Physical Address (If different from above):_____

Social Security #:_____ Email Address: _____

Employer:_____ Work Phone #:_____

Employer Address:_____

Spouse's Name:_____ Spouse's D.O.B.:_____ Spouse's Social Security #:_____

Spouse's Employer:_____ Spouse's Employer's Address: _____

Name of nearest relative (Not your spouse):_____ Phone# :_____

How did you learn of our office:_____ **Who Referred you?** _____
(If Yellow Pages, which phone book)

Is your visit due to an accident? (Auto or Work) Yes ☐ No ☐ (If yes, please receptionist for an injury report)

Your Present Complaint:_____ Briefly describe your symptoms and date this condition began:_____

_____

_____

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

Medical History (If any of the following are relevant to your medical history, please check accompanying box)

{} Cancer	{} Muscular Dystrophy	{} Rheumatic Fever	{} Carotid Artery Disease
{} Tuberculosis	{} Multiple Scierosis	{} Scarlet Fever	{} Digestive Disorders
{} High Blood Pressure	{} Convulsions	{} Nervousness	{} Sinus Trouble
{} Heart Trouble	{} Epilepsy	{} Asthma	{} Backaches
{} Diabetes	{} Concussion	{} Dizziness	{} Numbness
{} HIV/ARC	{} Hepatitis	{} German Measles	{} Arthritis
{} Aneurysm	{} AIDS	{} Pacemaker	{} Venereal Disease
{} Polio			

Describe any operations you've had and the dates:_____

Since your symptoms began, have you noticed a change in: ☐ Bowel Function? ☐ Bladder Function? ☐ No Change

Have you been treated by a physician for any health condition in the last year? ☐ Yes ☐ No

Describe Condition_____ Date of last physical exam:_____

Are you allergic to any medication ? ☐ Yes ☐ No What Kind?_____

Are you pregnant? ☐ Yes ☐ No Date of last menstrual period:_____

Do you have insurance? ☐ Yes ☐ No Insurance Company:_____

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that this office 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 this office will be credited to my account upon receipt. I permit this office to endorse co-issue remittances for the conveyance of credit to my account. However, I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. It is my understanding that my credit may be checked if Gadoury Chiropractic extends credit to me, and I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered to me will be immediately due and payable, unless prior arrangements are made. I hereby authorize the doctors at Gadoury Chiropractic and whomever they may designate as their assistants to administer treatment as they so deem necessary and also authorize the release of any information acquired in the course of my examination or treatment. I certify that the above information is true and correct.

*PLEASE NOTE: There will be a $25.00 returned check fee and a $15.00 no-show fee per session. There will be a 1.8% (of the total balance) late fee (service charge) added to my account at the end of every 30 days that the designated payment has not been paid. I understand that I am responsible for the charges of these late fees (service charges), and any other fees accrued for the collection of my account balance.

Patient's Signature (Parent or Guardian's if under18):_____