CONFIDENTIAL PATIENT INFORMATION

Full Name_____**Cell/Home Phone ( )** _____

Address_____**City**_____**ST**_____**ZIP**_____

Age_____ **Birth Date**_____**Marital Status: M S W D How many children?**_____

Occupation_____ **Employer**_____

Address_____ **City**_____**ST**_____**ZIP**_____

Phone ( )_____

Name of Husband or Wife_____ **Occupation**_____

Employer_____ **Office Phone ( )**_____

Emergency contact:_____ **Phone Number:**_____

Address_____**City**_____**ST**_____**ZIP**_____

Whom may we thank for referring you?_____ **Date of Last Physical Examination**_____

Email address:_____

☐ Anemia	☐ Diabetes	☐ High cholesterol	☐ Sinus trouble
☐ Arthristis	☐ Digestive disorders	☐ Neck pain	☐ Stroke
☐ Asthma	☐ Dizziness	☐ Nueritis	☐ Sugical implant
☐ Backache	☐ Epillepsy	☐ Nervousness	☐ Swelling of feet/ankle
☐ Birth Control	☐ Headache	☐ Rapid weight gain/loss	☐ Tobacco habit
☐ Cancer	☐ Heart trouble	☐ Radiation	☐ Tuberculosis
☐ Cortisone treatments	☐ High blood pressure	☐ Shortness of breath	☐ Other:_____

Purpose of this appointment_____

Other doctors seen for any condition in the past year_____

_____

Additional Information:_____

PAYMENT IS EXPECTED AT TIME OF VISIT!

Please request a superbill if you would like to seek reimbursement from your insurance company.

I authorize Hausrath Chiropractic to release all information necessary to secure the payment of benefits.
I understand I am directly responsible for all charges whether I am reimbursed by my insurance or not.

Patient's signature _____ Date:_____

Guardian or spouse signature _____ Date: _____

HAUSRATH CHIROPRACTIC
Lynn Peters, DC
428 Wilson Avenue
Richmond, CA 94805
(510) 236-4473