JOHNSTON CHIROPRACTIC CLINIC
CONFIDENTIAL PATIENT INFORMATION

Driver's License #: ______________________ Date: ______________

Name: ______________________________
Address: ______________________ City: ______________ State: _____ Zip Code: __________
Mailing Address *(if different from above)*: ______________ City: ______________ State: _____ Zip Code: __________
Home Phone #: ______________ Cell Phone #: ______________ Work Phone #: ______________
E-mail Address: ______________________________
Age: ______ Birth Date: ______________ Marital Status: ❑ Married ❑ Single ❑ Widow ❑ Divorced # of Children: ______
Employer: ______________________________ Occupation: ______________
Employer Address: ______________________ City: ______________ State: _____ Zip Code: __________
Spouse's Name: ______________________________
Spouse's Employer: ______________________________ Spouse's Work Phone #: ______________
Patient's Nearest Relative: ______________________________
Referred By: ______________________________
Date of last physical examination: ______________________________
What operations have you had? ______________________________ When? ______________
Serious Illnesses? ______________________________ When? ______________

Have You Suffered From:

Dizziness:	❑ Yes ❑ No	Tuberculosis:	❑ Yes ❑ No	Asthma:	❑ Yes ❑ No	Sinus Trouble:	❑ Yes ❑ No
Backache:	❑ Yes ❑ No	Arthritis:	❑ Yes ❑ No	Neuritis:	❑ Yes ❑ No	Anemia:	❑ Yes ❑ No
Heart Trouble:	❑ Yes ❑ No	Headaches:	❑ Yes ❑ No	Digestive Disorders:	❑ Yes ❑ No	Rheumatic Fever:	❑ Yes ❑ No
Diabetes:	❑ Yes ❑ No	Numbness:	❑ Yes ❑ No	Nervousness:	❑ Yes ❑ No	Cancer:	❑ Yes ❑ No

Purpose of this appointment: ______________________________
Other doctors seen for this condition: ______________________________
Have you been treated for any health condition by a physician in the last year? ❑ Yes ❑ No
Describe: ______________________________
What medications or drugs are you taking? ______________________________

IF YOURS IS AN ACCIDENTAL INJURY, PLEASE COMPLETE THE INFORMATION REQUESTED ON THE REVERSE SIDE

Remarks and additional information: ______________________________
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PAYMENT IS EXPECTED AT TIME OF VISIT!

Name of person responsible for payment: ______________________________
ARE YOU INSURED? ❑ YES ❑ NO COMPANY ______________________________

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that Johnston Chiropractic Clinic 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 Johnston Chiropractic Clinic will be credited to my account on receipt. However, I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered me will be immediately due and payable.

Patient's Signature: X______________________ Social Security #: X______________ Date: X__________
Guardian or Spouse's Signature Authorizing Care: ______________________ Date: __________
Information Taken By: ______________________ Date: __________