

## Patient Information

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Date: \_\_\_\_\_

Patient Name: \_\_\_\_\_

Street Address: \_\_\_\_\_

Mailing Address (if different): \_\_\_\_\_

City, State, Zip code: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Sex: **M / F** Marital Status: **Single / Married / Divorced / Widowed**

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ ext. \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Social Security Number: \_\_\_\_\_ Email address: \_\_\_\_\_

Driver's License - State & #: \_\_\_\_\_

Occupation: \_\_\_\_\_ Employer: \_\_\_\_\_

Employer's Address: \_\_\_\_\_

Student: **Full Time / Part Time / Not applicable**

Would you like to be included in our monthly "To Your Health" newsletter via your email? **Yes / No**

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# of children: \_\_\_\_\_ Names and ages: \_\_\_\_\_

Name of Spouse or Parent: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Social Security Number: \_\_\_\_\_ Occupation: \_\_\_\_\_ Employer: \_\_\_\_\_

Parent Address if Student not living at home: \_\_\_\_\_

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Purpose of this appointment: \_\_\_\_\_

Is your condition due to an accident? **Yes / No** Illness? **Yes / No** Other: \_\_\_\_\_

Was the accident at work? **Yes / No** Were you in an auto accident? **Yes / No** Other type of accident? **Yes / No**

Describe any accidental injury or related illness: \_\_\_\_\_

Other health professionals seen for this condition: \_\_\_\_\_

List any health conditions you have received treatment for in the last year: \_\_\_\_\_

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Who is your primary care physician? \_\_\_\_\_ Phone: \_\_\_\_\_

Would you like copies of our records sent to him/her? **Yes / No**

List any medications that you currently take: \_\_\_\_\_

List any surgeries you have had: \_\_\_\_\_

Are you interested in information on **nutritional supplementation to prevent disease and enhance wellness?** **Yes / No**

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How did you hear about our office? **Dr. Referral / Patient Referral / Advertisement / Yellow Pages / Other:** \_\_\_\_\_

Name of person who referred you to our office: \_\_\_\_\_

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**Payment is expected at the time of visit.** We have several plans available to make your treatment with us affordable.

Person responsible for payment of this account \_\_\_\_\_

Address if different from above: \_\_\_\_\_

If you have insurance coverage, please check any and all boxes that may apply in this case, fill out the **Insurance Information Form**, and present a copy of your insurance cards to the front desk.

Major Medical       Worker' Compensation       Medicare       Auto Insurance       Other

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*Welcome to Pinto Family Chiropractic - The Natural Choice for Health Care*