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

CONFIDENTIAL PATIENT INFORMATION

Name____ Social Security #___________________________

Address____ City____________ State_____ Zip Code___________

Home Phone____ Cell Phone __________________________________

Age________ Birth Date_____/_____/_______ Marital Status: __Married __Single __Widowed __Divorced

Occupation____ Employer____

Employer Address____ Office Phone________________________

Email ____ Do we have your permission to send you emails? __Yes __No

Name of Spouse____ Spouse's Phone_____________________________

Emergency Contact______________________________________ Phone_____________________________________

Date of Last Physical Exam__________________ Medical Doctor's Name____________________________________

How did you hear about our office? ____

Have you ever suffered from (mark all that apply):

__ Dizziness __Backaches __Heart Trouble __Diabetes __Tuberculosis __Arthritis __Headaches

__Asthma __Neuritis __Digestive Issues __Nervousness __Sinus Issues __Anemia __Cancer

Females: Is there a chance you could be pregnant? __Yes __No

Reason for this appointment ____

Other doctors seen for this condition ____

Payment is expected at time of visit Name of person responsible for payment________________________________

Are you insured? __Yes __No Company____

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/ Guardian Signature ____ **Date**________________________