TRAINOR FAMILY CHIROPRACTIC 1915-A WESTFIELD AVE. SCOTCH PLAINS, NJ 07076

PATIENT INFORMATION

Last Name ______ First Name ______ MI ______ SSN ____ - ____ - ____

Address ______ City ______ State ______ Zip ______

Cell ____ - ____ - ____ Work or home Phone ___ - ___ - ___ Email ______

From time to time we may need to contact you regarding a missed appointment or emergency office closing. Do we have permission to leave a message for you? ❏ Yes ❏ No What is your preferred method of contact? ❏ Email ❏ Text ❏ Phone

Emergency Contact: Name ______ Phone ____ - ____ - ____ Rel to patient: ______

Date of Birth	Sex	Marital Status	Preferred Language	Ethnicity
____/____/____ Month Day Year	❏ Male ❏ Female	❏ Married ❏ Single ❏ Widowed ❏ Divorced	❏ English ❏ Spanish ❏ Other ______	______ Race ______

EMPLOYMENT INFORMATION

Employer ______ Position ______ Office Phone (____)____-____

Address ______ City ______ State ______ Zip ______

INSURANCE/REFERRAL INFORMATION

Responsible Party (Subscriber/Policyholder) ______ Relationship to Patient (Self, Spouse, Child, Other) ______

____/____/____
Date of Birth (for Insurance policyholder)

Referred to Dr. Trainor by: ______

Address if different from above ______

❏ Medicaid ❏ Medicare ❏ Workman's Compensation ❏ Auto Injury ❏ Personal Insurance

Insurance Company ______ Plan Type (HMO, PPO) ______ Group#/ID # ______

Is patient covered by additional or supplemental insurance? ❏ Yes ❏ No

ASSIGNMENT AND RELEASE

I plan to pay by: ❏ Cash ❏ Check ❏ Credit Card (MasterCard, Visa, Amex or Discover)

I certify that the above information is true and correct. I, the undersigned, certify that I (or my dependent) have insurance coverage as shown above (or by copy of insurance card) and assign directly to Dr. Trainor all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize Dr. Trainor to release any information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Signature ______ Date______

(Please turn over and complete other side)

Patient Information

Main Complaint and Symptoms: ______ ______	List any previous accidents or injuries: ______ ______
When did you first notice this problem? ______	List any major illnesses: ______ ______
How does this condition interfere with normal living or working? ______	List any operations: ______ ______
Was your condition caused by: ❏ Auto ❏ On the job ❏ Other Describe Accident if applicable: ______	Are you currently under any doctor's care? ❏ Yes ❏ No (If yes, who and why?) ______ ______
Have you had any previous treatment for this or similar conditions? ❏ Yes ❏ No If yes, what were dates of treatment/ How long were you treated? ______ Name of Doctor that treated you ______ Results? ______ Is there any possibility that you may be pregnant? ❏ Yes ❏ No First day of your last menstrual period: Date and month: ____/_____	Are you currently taking any medication? ❏ Yes ❏ No (List names of medication/what they are treating) ______ ______ ______ ______ ______ Please list any allergies______ ______ ______
Have you been under previous chiropractic care? ❏ Yes ❏ No If yes, who treated you? ______	Smoking Status ❏ Current Every Day smoker ❏ Current Some Day smoker ❏ Never smoked ❏ Former Smoker, quit date ____/____/_____

Doctor's Notes

______

______

BP: / ____ HT______ WT _____ BMI ____ SM/CESS _____