Sunland Chiropractic Center
Patient Registration

Patient Information

Name:	Home Phone:	Cell / Mobile Phone:

Address:	City:	State:	Zip:

Sex:	Marital Status:	Birth date:	Age:	# Of Children:	S/S#
☐ M ☐ F	☐ S ☐ M ☐ D ☐ W				

Occupation:	Employed by:	Work Address:	Work Phone Number:

Spouses name (Or Parent):	Spouses (Or Parent) Employer:	*Who may we thank for referring you to our office?*

Have you ever had Chiropractic Care before?	Would you like to receive our monthly newsletter by email? ☐ Yes ☐ No	Your email address is:
☐**Yes** ☐**No** If yes, when?		

List your chief complaints in order of severity:

1. ______________________________ **For how long?** ______________

2. ______________________________ **For how long?** ______________

3. ______________________________ **For how long?** ______________

How did this condition or injury happen? ______________________________

Is this injury or illness work related? ☐Yes ☐No Have you reported it to your employer? ☐Yes ☐No Date of injury: ______________

Is this injury due to an automobile accident? ☐Yes ☐No (If yes, please give us your information:)

Auto Insurance Co. ______________ Policy#: ______________ Claim #: ______________

Agents Name: ______________ Address: ______________ Phone: ______________

Do you have any type of health insurance? ☐**Yes** ☐**No** *If yes, please provide us with the following information:*

Insurance Company Name: ______________ Policy Number: ______________

Name of the primary insured on the policy: ______________ Your relation: ______________

Are you covered under any other group or individual health policy through yourself or spouse? *(i.e.: secondary or supplemental policy)* ☐Yes ☐No

If yes, Insurance Company Name: ______________ Employer______________

Spouses Social Security Number: ______________ Spouses date of birth: ______________ Policy #: ______________

Have you seen another doctor for this condition? ☐ **No** ☐ **Yes (If Yes, Please give Dr.'s name)** ______________

What medications are you currently taking? ______________________________

Please list any surgical operations you have had: ______________________________

Do you have a pacemaker? ☐ **Yes** ☐ **No**

Have you or any of your family members had any of the following conditions? ***Check off all that apply***

☐ Stroke	☐ Arthritis	☐ Digestive disorders	☐ Headaches	☐ Backaches	☐ High Blood Pressure
☐ Diabetes	☐ Neuritis	☐ Immune disorders	☐ Dizziness	☐ Asthma	☐ Heart Attack
☐ Cancer	☐ Anemia	☐ Heart disease	☐ Neck pain	☐ Tuberculosis	☐ other

Assignment And Release

I, the undersigned certify that I (or my dependent) have insurance coverage with ______________ and assign directly to Roderick L. Chapman, D.C. 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 the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance claim submissions.

Responsible Party's Signature ______________ **Relationship to patient** ______________ **Date** ______________