



406 E. South Blvd., Crawfordsville, IN 47933 | (765) 362 1111 | www.russellfamilychiro.com

PATIENT INFORMATION & CONDITION FORM

Patient Name: \_\_\_\_\_ Today's Date: \_\_\_/\_\_\_/\_\_\_

Social Security Number \_\_\_\_\_ Birth Date: \_\_\_/\_\_\_/\_\_\_ Age: \_\_\_ Gender: F M

If you are under 18 years of age, who are your legal parents or guardian?

Father: \_\_\_\_\_ Date of Birth: \_\_\_/\_\_\_/\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_

Mother: \_\_\_\_\_ Date of Birth: \_\_\_/\_\_\_/\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_

Guardian: \_\_\_\_\_ Date of Birth: \_\_\_/\_\_\_/\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_

Who do you normally live with?  Mother and Father  Father  Mother  Legal Guardian  None of these

Marital Status:  Married  Separated  Widowed  Single How many children? \_\_\_\_\_

Email Address: \_\_\_\_\_

CURRENT ADDRESS

Street \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Phone (\_\_\_\_) \_\_\_\_\_

OTHER ADDRESSES WHERE YOU RESIDE (e.g., parents' home, any other address where you regularly reside)

Street \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Phone (\_\_\_\_) \_\_\_\_\_

Your Occupation \_\_\_\_\_ Employer \_\_\_\_\_

Work Address \_\_\_\_\_ Work Phone (\_\_\_\_) \_\_\_\_\_

Student at \_\_\_\_\_  FULL-TIME  PART-TIME

Name of Spouse \_\_\_\_\_ Spouse's Date of Birth \_\_\_/\_\_\_/\_\_\_

Spouse's Occupation \_\_\_\_\_ Spouse's Employer \_\_\_\_\_

Spouse's Work Address \_\_\_\_\_ Work Phone (\_\_\_\_) \_\_\_\_\_

Spouse is a student at \_\_\_\_\_  FULL-TIME  PART-TIME

Who should we contact in the event of an emergency? \_\_\_\_\_ Phone (\_\_\_\_) \_\_\_\_\_

Address of contact person \_\_\_\_\_

How did you learn about us? \_\_\_\_\_

Is your condition or injury due to an accident or work-related cause?  YES  NO Please check ALL that apply.

Did the condition or injury result from automobile accident?  YES  NO

Did it result from a work-related accident or cause?  YES  NO (briefly describe): \_\_\_\_\_

If the condition did not result from an automobile accident or relate to your work, where did the accident occur? \_\_\_\_\_

Approximately, when did your injury or condition occur? \_\_\_/\_\_\_/\_\_\_

Describe your condition, symptoms, or the purpose of this appointment: \_\_\_\_\_

Have you ever had the same or similar condition?  YES  NO If yes, when and describe: \_\_\_\_\_

Please indicate any other healthcare providers who you've seen for this injury or condition, and when you last saw them.

Name: \_\_\_\_\_ Type of Practice: \_\_\_\_\_ Date of Last Visit: \_\_\_/\_\_\_/\_\_\_

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Name: \_\_\_\_\_ Type of Practice: \_\_\_\_\_ Date of Last Visit: \_\_\_/\_\_\_/\_\_\_

Date of last physical examination? \_\_\_\_\_

What surgery have you had? \_\_\_\_\_ When? \_\_\_\_\_

Serious illnesses or conditions? \_\_\_\_\_ When? \_\_\_\_\_

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? \_\_\_\_\_

Have you ever suffered from:

- Dizziness
- Backaches
- Heart Trouble
- Diabetes
- Hernia
- Arthritis
- Headaches
- Numbness
- Asthma
- Neuritis
- Digestive Disorders
- Nervousness
- Sinus Trouble
- Anemia
- Cancer

WOMEN ONLY: Are you pregnant or is there any possibility you may be pregnant?  YES  NO  UNCERTAIN

Do you have health insurance?  YES  NO  Not Sure Company: \_\_\_\_\_

Full Name of Policy Holder: \_\_\_\_\_ Policy Holder's Date of Birth \_\_\_/\_\_\_/\_\_\_ Does the policy holder

have the insurance through his/her employer?  YES  NO If yes, who is the employer? \_\_\_\_\_

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I understand and agree that health and accident insurance policies are an arrangement between my insurance company and myself -- not between my insurance company and this office. I agree to pay my estimated patient responsibility and further understand that the estimated responsibility is neither a guarantee of payment by my insurance company, nor necessarily an accurate reflection of my actual responsibility as determined by my insurance company upon processing of my claims. In the event that my insurance company does not pay on my charges at the estimated rate or within a reasonable period of time, upon request of this office I will immediately pay the balance owing on my account unless otherwise agreed to in writing. I understand that an interest charge may appear on all accounts over 90 days. I further understand and agree, that if this office must take any action to collect an outstanding balance on my account, I will be responsible for payment and will reimburse this office for all costs of such collection efforts, including, but not limited to, all court costs and attorney fees.

I authorize this office to release any medical information relating to my treatment to any insurance companies which may be responsible for paying benefits to me, and to any attorneys who may be representing me due to my condition, and to complete any usual and customary reports and forms at no charge to assist in collecting from my insurance companies, attorneys, or other payers.

I have read, understood, and agree to the foregoing. The information which I have provided is true and complete to the best of my knowledge.

Patient's Signature: \_\_\_\_\_ Date: \_\_\_/\_\_\_/\_\_\_