

CONFIDENTIAL PATIENT INFORMATION

Chiropractic Center
1935 N.E. 39th Ave.
Portland, OR 97212

Date: _____ Full Name: _____ Phone: _____

Address: _____
Street City State Zip

Name of Spouse or Guardian: _____ E-mail: _____

Marital Status: M S W D Age: _____ Birth Date: _____

Pregnant? Y N Unsure Oregon Driver's License #: _____ SS#: _____

Height: _____ Weight: _____ Occupation: _____

Employer: _____ Employer Phone: _____

Who may we thank for referring you to us? _____

Medical doctors or chiropractors you have seen in the past year:

Name: _____ Reason: _____

Name: _____ Reason: _____

Reason for this appointment & related health problems:	Date started or For how long?	Have you had This before?	Injury Related?
1. _____	_____	Yes/No	Yes/No
2. _____	_____	Yes/No	Yes/No
3. _____	_____	Yes/No	Yes/No

Previous surgeries (Please list all types):

1. Type: _____ Date: _____

2. Type: _____ Date: _____

Previous accidents or injuries, especially those that relate to your present problem(s):

1. Type: _____ Date: _____

2. Type: _____ Date: _____

INSURANCE INFORMATION

Patient's name: _____

Insured's name: _____ Phone: _____

Insured's address: _____
Street City State Zip

Insured's ID# or SS#: _____

Insured's Group name or #: _____

Name of insurance company: _____ Phone: _____

Insurance company address: _____
Street Suite or P.O. Box # City State Zip

Current medications:

Please circle the following conditions you may have had or have now:

Allergy	Alcoholism	Anemia	Arthritis
Back aches	Constipation	Convulsions	Cold sores
Cancer	Diabetes	Sinus	Venereal disease
Eczema	Gall Bladder	Heart attack	High blood pressure
Stroke	Epilepsy	Measles	Blood vessel disease
Headaches	Heart Disease	Ulcers	Multiple sclerosis
Neck pain	Back pain	Polio	Menstrual cramps
Mumps	Diarrhea	Whooping cough	Irregular periods
Neuritis	Nervousness	Depression	Thyroid problems
Gout	Pneumonia	Pleurisy	Low blood sugar
Malaria	Tuberculosis	Migraine	Miscarriage

Other: _____

PAYMENT POLICIES

1. Payment for your first day's visit is due at the completion of your office visit.
2. At the completion of your first office visit, you will be advised as to a time when you can return for your second consultation. At that time, the doctor will inform you of the result of your examination, and whether or not your case has been accepted. You will then also be advised concerning financial arrangements and insurance coverage as appropriate.

ASSIGNMENT & RELEASE

I authorize release of information to family physician(s) and employer(s).

I authorize release of information to insurance companies.

I authorize the taking of photographs and x-rays to be used for treatment purposes.

I authorize the performance of other diagnostic and therapeutic procedures for treatment purposes.

I authorize my insurance benefits to be paid directly to:

Dr. William J. Schneider

**1935 N.E. 39th
PDX, OR 97212**

I acknowledge that I am financially responsible for non-covered services, and fees for professional services rendered me will be immediately due and payable.

Patient signature: _____ Date: _____

Guardian's signature: _____ Date: _____