Ellet Injury Center
"Getting You BACK To Well"

Dr. Martin Vaught
Chiropractor

Date ____________________

CONFIDENTIAL PATIENT INFORMATION

Social Security # ____________________

Name ____________________ Home Phone ____________________

Address ____________________ City ____________ State ______ Zip Code __________

Age ______ Birth Date ______________ Marital Status: ☐ Married ☐ Single ☐ Widowed ☐ Divorced No. of children? ______

Occupation ____________________ Employer ____________________

Address ____________________ Office Phone ____________________

Email Address: ____________________

Name of Wife or Husband ____________________ Occupation ____________________

Employer ____________________ Office Phone ____________________

Patient's Nearest Relative ____________________ Address ____________________

Phone Home # ____________________ Phone Work # ____________________

Referred by ____________________

Who should we contact in case of emergency? ____________________ Phone# ____________________

Date of Last Physical Examination ____________________

Have You Ever Suffered From:

	YES	NO		YES	NO
1. Dizziness	☐	☐	8. Asthma	☐	☐
2. Backaches	☐	☐	9. Neuritis	☐	☐
3. Heart Trouble	☐	☐	10. Digestive Disorders	☐	☐
4. Diabetes	☐	☐	11. Nervousness	☐	☐
5. Tuberculosis	☐	☐	12. Sinus Trouble	☐	☐
6. Arthritis	☐	☐	13. Anemia	☐	☐
7. Headaches	☐	☐	14. Cancer	☐	☐

Reason for this Appointment ____________________

Other Doctors seen for this Condition ____________________

Have you been treated for any health condition by a physician in the last year? ☐ YES ☐ NO

Describe: ____________________

Remarks and additional information: ____________________

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PAYMENT IS EXPECTED AT THE TIME OF VISIT! Will you be paying today by: ☐ Cash; ☐ Check; ☐ Credit Card

Name of Person Responsible for Payment: ____________________

Are You Insured? ☐ YES ☐ NO Company: ____________________ Policy # ____________________

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that PRO CHIROPRACTIC CENTER will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to PRO Chiropractic will be credited to my account on receipt. However, I clearly understand and agree that any services rendered me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered me will be immediately due and payable.

Patient's Signature: ____________________ Date: ____________

Guardian or Spouse's Signature: ____________________ Date: ____________

Information Taken By: ____________________ Date: ____________