Patient File Update

Patient Name: _____ Date: _____

Email: _____ Cell Phone: _____

General Physician: _____MD Phone _____Fax_____

Smoker: _____ (Amt.) Former Smoker: _____Blood Type _____

Allergies: _____

Relevant Family History: _____

_____

List of Current Medications (Dosage)/ Supplements:

_____
_____
_____
_____
_____
_____

_____

Currently not on Medications: _____Currently not on Supplements: _____

Ethnicity: _____Preferred Language:_____ Race: _____

I certify that the above information is accurate to the best of my knowledge, grant Advanced Chiropractic Health Center permission to access my health information when necessity, acknowledge that visit summaries are available upon request or through the Practice Fusion portal and that patient education material is made available upon every visit, as well as grant permission to send reports to my physicians.

Patient Signature: _____

Height: _____ Weight: _____ BP: _____ Pulse: _____ RESP: _____ Date: _____

Height: _____ Weight: _____ BP: _____ Pulse: _____ RESP: _____ Date: _____