Davis Chiropractic

Dr. John C. Davis & Dr Harold Adkins
20461 DuPont Blvd. • Ste. 1 • Georgetown, DE 19947
(302) 856-2225 / Fax: (302) 856-6618

PATIENT UPDATE

Last Name______________ First Name______________ Middle________ Birth date____/____/____

Address______________ City______________ State________ Zip________

Home Phone (____)_____-______ Work Phone (____)_____-______ Cell Phone (____)_____-______ SS#_____-_____-_____

Email______________ Occupation______________ Patient Employer / School ______________

Contact Phone (____)_____-______ Current Smoking Status- CURRENT PREVIOUS NEVER

SPOUSE / PARENT / OTHER: Name ______________ Shoe size- ______________

INSURANCE UPDATE

Policy Holder Name: ______________ Relationship to Patient ______________

Insurance Company______________ ID #______________ Group #______________

Policy Holder Address: ______________ City______________ State________ Zip________

Policy Holder Birth date ______/______/______ Policy Holder SS#_____-_____-_____

Is patient covered by additional insurance? ☐ No ☐ Yes

If Yes, Insurance Company______________ ID #______________ Group #______________

ASSIGNMENT AND RELEASE

I certify that I, and /or my dependent(s), have insurance coverage with the above company(ies), and assign directly to ***Dr. John Davis*** 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 authorize the use of my signature on all insurance submissions.

The above-named doctor may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

Patient/Parent/Guardian/Personal Representative *Signature* ______________

Patient/Parent/Guardian/Personal Representative *Printed Name* ______________

Date ______/______/______ Relationship to Patient ______________

Is Your Condition Due To An Accident? ☐ NO ☐ YES

Date of Accident______/______/______ Type Of Accident: ☐ Auto ☐ Work ☐ Home ☐ Other

To whom has the accident been reported to? ☐ Auto Insurance ☐ Employer ☐ Worker Comp. ☐ Other

Attorney Name (if applicable) ______________

PATIENT NAME ___________________________________

Office Use Only:
Height_________________
Weight_________________
BP _______________ L or R
Heart _______ 02% ______

CONDITION UPDATE

Please check any that apply, and provide dates and details.

☐ Recent Fall(s) ___________________________________ ☐ Recent Surgery ___________________________________

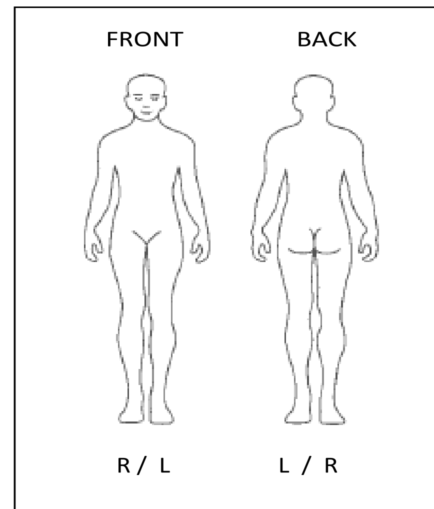
☐ Recent Accident(s)________________________________ ☐ Last Physical _____________________________________

☐ Last Adjustment _________________________________

Area of Primary Complaint___________________________ Area of Secondary Complaint:____________________________

Level of Primary Pain: Minimal Mild Moderate Severe Level of Secondary Pain: Minimal Mild Moderate Severe

Mark an X on the picture where you have pain, numbness, or tingling.



When did your symptoms appear? _____________________________________

Is this condition getting progressively worse? ☐ Yes ☐ No

Type of pain:

☐ Sharp ☐ Burning ☐ Tingling ☐ Shooting ☐ Cramps ☐ Aching

☐ Stiffness ☐ Numbness ☐ Swelling ☐ Throbbing ☐ Other _____________

How often: 0-25% of day 25-50% of day 50-75% of day 75-100% of day

Does it interfere with your: ☐ Sleep ☐ Work ☐ Daily Routine ☐ Recreation

Activities that are painful to perform:

☐ Sitting ☐ Standing ☐ Walking ☐ Bending ☐ Lying Down

Additional notes: ____

____

____

LIST CURRENT MEDICATIONS/NUTRITIONAL SUPPLEMENTS YOU ARE TAKING

I understand that as a patient of this clinic, I am authorizing the staff to proceed with any further treatment that may be necessary in my care. Furthermore, any risks involving such treatment will be explained to me upon request.

____ Date_________

Patient/ Parent/ Guardian/ Personal Representative Signature