Confidential Patient Information

Ball Chiropractic Center | 1717 S 324th St # B, Federal Way, WA 98003 | Phone (253) 838-6909 FAX (253) 661-3610

Date Age D.O.B. (Mo/Day/Year) Sex Marital Status

First & Last Names E-mail

Street Address Apt# City State Zip Code

Phone ( ) Work Phone ( ) Social Sec #

Occupation Employer Location

Guardian/Spouse's Full Name D.O.B. Social Sec #

Occupation Employer Location

Name, work phone and city of nearest relative (not your spouse):

Were you referred to a certain doctor in this office? Is your visit due to an accident? ☐ No ☐ Yes

YOUR PRESENT COMPLAINT(S)

List other doctor(s) seen for this condition:

Personal Medical history (if any of the following are relevant to your medical history, please check the accompanying box:)

☐ Cancer	☐ Muscular Dystrophy	☐ Rheumatic Fever	☐ Digestive Disorders
☐ Polio	☐ Multiple Sclerosis	☐ Scarlet Fever	☐ Sinus Trouble
☐ Tuberculosis	☐ Convulsions	☐ Nervousness	☐ Backaches
☐ Arthritis	☐ Epilepsy	☐ Asthma	☐ Numbness
☐ Heart Trouble	☐ Concussion	☐ Dizziness	☐ High Blood Pressure
☐ Diabetes	☐ Hepatitis	☐ German Measles	☐ Venereal Disease

Describe any operations you've had and the dates:

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

Describe Condition Date of last physical exam

Are you now taking any medication? ☐ Yes ☐ No. What kind?

Are you allergic to any medication? ☐ Yes ☐ No. What kind?

Are you pregnant? ☐ Yes ☐ No. Date of last menstrual period:

Do you have insurance? ☐ Yes ☐ No. Company I.D. No. Policy Group No.

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that this office 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 this office will be credited to my account upon receipt. I permit this office to endorse co-issued remittances for the conveyance of credit to my account. However, I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. It is my understanding that my credit may be checked if Ball Chiropractic Center extends credit to me and I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered to me will be immediately due and payable unless prior arrangements are made. I hereby authorize the doctors at Ball Chiropractic Center and whomever they may designate as their assistants to administer treatment as they so deem necessary and I also authorize the release of any information acquired in the course of my examination or treatment. I certify that the above information is true and correct.

Patient's (Parent or Guardian's) Signature