MORACK CHIROPRACTIC CENTER, P.C.

PERSONAL HISTORY FORM

Date: _____ Social Security Number: _____

Name: _____

Street Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Cell Phone: _____

Date of Birth: _____ Sex: Male / Female Height: _____ Weight: _____

Circle if you are: Single Married Widowed Divorced Separated

Employer: _____

Type Of Work: _____

Spouse Name: _____

Ages of Children: _____

Referred To This Office By: _____

Who Is Responsible For Your Bill?: ( ) Self ( ) Spouse ( ) Employer

( ) Insurance ( ) Other: _____

Nearly all insurance policies provide chiropractic coverage, but benefits vary form company to company and from policy to policy. Therefore, although our office will fill out insurance forms, the patient is personally responsible for payment of the bill. We do accept certain insurance assignments but all insurance arrangements must be approved in advance with the business office.

I hereby authorize the Doctor to examine and treat my condition as he/she deems appropriate through the use of chiropractic health care, and I give authority for these procedures to be performed. The Doctor will not be held responsible for any pre-existing medically diagnosed conditions nor for any medical diagnosis.

_____ _____

Patient Signature Date