THOMAS D. ROSE, DC **Today's Date _____**

CONFIDENTIAL PATIENT INFORMATION

Social Security# _____/_____/_____ Birth date _____/_____/_____ Age _____

Patient Name _____ Home Phone _____/_____/_____

(Legal) First Middle or Initial Last Cell Phone _____/_____/_____

Circle one: Single Married Divorced Widowed

Mailing Address _____ City _____ State _____ Zip_____

Street Address (If different from mailing address) _____

Spouse/Parent/Guardian Name _____Relationship to patient_____

Mailing Address _____ City _____ State _____ Zip_____

Patient's Employer _____ Work Phone _____/_____/_____

Employer's Address _____ City _____ State _____ Zip_____

(Circle if applicable) Work Related Injury/Auto Accident/Home Injury: Y / N (If yes, please complete the back of this form)

Referred by _____ (Dr. or Other Individual) Date of Last Physical Exam _____/_____/_____

Purpose for this Appointment _____ Other Doctors seen for this condition _____

When Did Problem Start _____ Date of Most Recent Occurrence _____

Have you been treated for any health condition by a physician in the last year? _____ If yes, describe:_____

Have you ever suffered from:

Dizziness ____ Backaches ____ Heart Trouble ____ Diabetes ____ Tuberculosis ____ Arthritis ____ Headaches ____ Asthma ____

Neuritis ____ Digestive Disorders ____ Nervousness ____ Anemia ____ Sinus Trouble ____ Rheumatic Fever ____

PLEASE READ: ***I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier, my employer, and myself. Furthermore, I understand that the Sevier Valley Chiropractic Clinic 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 the Sevier Valley Chiropractic Clinic will be credited to my account upon receipt of such payment. However, I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment including any collection, court, or attorney fees. I also agree that if I suspend or terminate my care and treatment, any fees for professional services rendered me will be immediately due and payable.***

PRIMARY Insurance Company _____ _____ Policy# _____

Insured's Name _____ Birth date ____/____/____ Social Security# _____/_____/_____

(Legal) First Middle or Initial Last

Insured Address _____ City _____ State_____ Zip_____

SECONDARY Insurance Company _____ Policy# _____

Insured's Name _____ Birth date ____/____/____ Social Security# _____/_____/_____

(Legal) First Middle or Initial Last

Insured Address _____ City _____ State_____ Zip_____

_____ _____

PATIENT'S SIGNATURE **GUARDIAN/SPOUSE'S SIGNATURE**