WEDDINGTON CHIROPRACTIC
WELLNESS CENTER

www.weddingtonwellness.com

ABOUT YOU

Today's Date: _____ File #: _____

Patient Name: _____
LAST FIRST MI

What do you prefer to be called: _____ ☐ Male ☐ Female

Birthdate: _____ Age: _____ SS#: _____

Mailing Address: _____
CITY STATE ZIP CODE

Home Phone #: _____ Work Phone #: _____ EXT _____

Cell Phone #: _____ Email: _____

Referred By: _____

Employer: _____ How Long: _____

Employer Address: _____
CITY STATE ZIP CODE

Occupation: _____

Status: ☐ Minor ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed

Spouse's Name: _____ Children: ☐ Yes ☐ No How Many: _____

Would you like to receive text and or email appointment reminders from our office? ☐ Yes ☐ No

If yes, please provide our office with your cell phone carrier: _____

INSURANCE INFORMATION

Primary Insurance:

Company Name: _____ Phone Number: _____

Address: _____
CITY STATE ZIP CODE

Insured's ID #: _____ Group #: (Plan, Local or Policy #) _____

Insured's Name: _____ Relation: _____ Date of Birth: _____

Insured's Employer: _____

Secondary Insurance:

Company Name: _____ Phone Number: _____

Address: _____
CITY STATE ZIP CODE

Insured's ID #: _____ Group #: (Plan, Local or Policy #) _____

Insured's Name: _____ Relation: _____ Date of Birth: _____

Insured's Employer: _____

IN CASE OF EMERGENCY

Whom should we contact? _____ Relation: _____

Home Phone #: _____ Work Phone #: _____ Cell Phone #: _____

Who is your Medical Doctor? _____ Medical Doctor's Phone #: _____

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NEW PATIENT INFORMATION

Name: _____ DOB: _____ Age: _____ Date: _____

Are you Right or Left Handed: _____ Height: _____ Weight: _____ ☐ Male ☐ Female

Language : _____ Race: _____

Do You Currently Smoke: ☐ Yes ☐ No How many per day? _____ ☐ Former ☐ Never

Occupation: _____

How did you hear about our office? _____

Main reason for today's visit: _____

Date of Recent Problem: _____

Is the problem: ☐ Worse ☐ Better ☐ Not Changed

Which services have you had before? ☐ Chiropractic ☐ Acupuncture ☐ Physical Therapy ☐ Medical ☐ Massage ☐ Naturopathy ☐ Other

Was it for the current problem? _____

If not, when and for what issue? _____

Have there been any injuries, surgeries, medications, allergies or medical changes in the last two years?

_____

_____

Please provide us with the contact information of your Primary Care Physician: _____

Name: _____ Phone #: _____

DOCTOR'S NOTES

BP: _____ Insurance: _____