MERRITT CHIROPRACTIC OFFICE

500 Colorado Avenue, Stuart, FL 34994
772-220-2282

CONFIDENTIAL PATIENT INFORMATION

This information is confidential. We will not share any information outside this office without permission from you, the patient.

Last Name _____First Name_____ Middle Initial_____
Street Address_____City and State_____Zip_____
Age____ Date of Birth_____ Married ☐ Single ☐ Number of Children_____
Home Phone _____ Cell Phone _____
Occupation _____ Work Phone _____
E-mail Address_____
Referred by _____

Have you ever seen a Chiropractor before? **Y N**
If female, is it possible you are pregnant? **Y N**

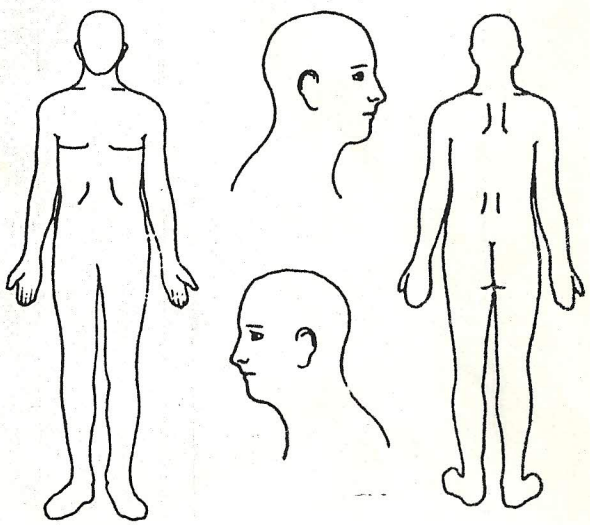
List present complaints, injuries and duration:

1. _____
   How long?_____
2. _____
   How long?_____

Other information you feel doctor should have:

_____
_____
_____

Please mark your **areas** of pain on the figures below.



List other doctors consulted for present complaints and injuries:

Name_____What kind of Dr._____When consulted_____
Diagnosis_____How long did you see the Dr.?_____How frequently?_____
Name_____What kind of Dr._____When consulted_____
Diagnosis_____How long did you see the Dr.?_____How frequently?_____

List former serious accidents and falls: (auto, work, home, leisure, sports, childhood, etc. – circle one)
What/When/Symptoms/Treatment/Results_____
_____

It is the policy of Merritt Chiropractic Office to wait for payment from a third party or insurance company. This policy exists to help our patients receive care when they need it without financial barriers. I hereby assign Merritt Chiropractic Office insurance benefits and any causes of action on all insurance policies otherwise payable to me. I am financially responsible for any deductible, co-payment or non-covered services. I further authorize Merritt Chiropractic Office to release information necessary to apply for payment for these benefits.

_____ _____
Date Patient, Parent, or Guardian Signature