CONFIDENTIAL PATIENT INFORMATION

CLEARVIEW CHIROPRACTIC WELLNESS CENTER, P.C.
Casey Titus, D.C.
1 Ocean Boulevard #104
Southern Shores, NC 27949
Ph: (252) 261-3100 Fax: (252) 261-3240 cetdc@aol.com

Name ______________________ **Date of Birth** ______________ **Gender** M F

Social Security # ______________ **Marital Status**: S M D W Sep **# of Children:** ______

Home Phone ______________ **Address** ______________

Work Phone ______________ **City/ST/ZIP** ______________

Cell Phone ______________ **Employer** ______________

Referred By ______________ **Occupation** ______________

Spouse's Name ______________ **Email Address** ______________

Emergency Contact ______________ Phone ________ Relationship ________

Have you *EVER* suffered from: *(check all that apply)*

1. Dizziness	☐ YES / ☐ NO	8. Ringing in the ears	☐ YES / ☐ NO	14. Difficulty Sleeping	☐ YES / ☐ NO
2. Backaches	☐ YES / ☐ NO	9. Headaches	☐ YES / ☐ NO	15. Nervousness	☐ YES / ☐ NO
3. Allergies	☐ YES / ☐ NO	10. Migraine	☐ YES / ☐ NO	16. Diabetes	☐ YES / ☐ NO
4. Asthma	☐ YES / ☐ NO	11. Leg Pain/Sciatica	☐ YES / ☐ NO	17. Digestive Disorders	☐ YES / ☐ NO
5. Fatigue	☐ YES / ☐ NO	12. Sinus Trouble	☐ YES / ☐ NO	18. Cancer	☐ YES / ☐ NO
6. Arthritis	☐ YES / ☐ NO	13. Numbness/tingling in the extremities	☐ YES / ☐ NO	19. Heart Trouble	☐ YES / ☐ NO
7. Neck Pain	☐ YES / ☐ NO			20. Tuberculosis	☐ YES / ☐ NO

HEALTH INFORMATION:

Purpose of this appointment ______________

Other doctors seen for this condition ______________

Have you been seen for any health condition by a physician in the last year? **YES** or **NO**

◆Doctor seen & reason ______________

Have you had previous Chiropractic care? **YES** or **NO** By whom ______________

Previous illnesses ______________

INSURANCE INFORMATION:

Insurance Company ______________ Policy/Subscriber ID ______________

Policy Holder's Name ______________ Date of Birth ______________ SSN ______________

Secondary Insurance ______________ Policy/Subscriber ID ______________

Policy Holder's Name ______________ Date of Birth ______________ SSN ______________

*** Please provide your Insurance ID Card at the front desk so we may make a copy for our records and billing.**

I will be paying today by: **Cash** **Check** **Credit / Debit Card**

I understand and agree that, (regardless of my insurance status) I am ultimately responsible for the balance on my account for any professional services rendered. I have read all the information on both sides of this sheet and have completed the above answers. I certify this health information is true and correct to the best of my knowledge. I will notify you of any changes in my health status or the above information.

Signature ______________________ Date ______________

*Responsible Party signature ______________________ Date ______________

**Required if any person other than the patient being treated is preparing this form. Signature indicates consent to care of a minor child.*