Chiropractic Center of West Greenwich

Sherry B Morrissette, D.C., D.A.C.N.B.

Name_____Home Phone_____Cell_____

Address_____City_____State_____Zip Code_____

Email Address_____Cell carrier_____

Age_____ DOB_____ Marital Status ☐ M ☐ S ☐ W ☐ D Number of Children_____

Employer_____ Occupation_____

Work Address_____ Work Phone_____

Name of Wife/ Husband / Significant Other_____Occupation_____

Employer_____ Work Phone_____

Patient's Nearest Relative_____ Address_____

Phone Number_____Office Phone_____

Referred By_____ ☐ Newspaper ☐ Yellow Pages ☐ Self ☐ Coupon

Preferred method of appointment reminder ____text____email Permission to leave messages: ____home____cell

Date of last physical examination_____

Have you ever suffered from:

	Yes	No		Yes	No		Yes	No
1. Dizziness	☐	☐	6. Arthritis	☐	☐	11. Nervousness	☐	☐
2. Backaches	☐	☐	7. Headaches	☐	☐	12. Sinus Trouble	☐	☐
3. Heart Trouble	☐	☐	8. Asthma	☐	☐	13. Anemia	☐	☐
4. Diabetes	☐	☐	9. Neuritis	☐	☐	14. Cancer	☐	☐
5. Tuberculosis	☐	☐	10. Digestive Dis	☐	☐			

Reason for this appointment_____

Other doctors seen for this condition_____

Have you been treated by a physician in the last year? ☐ Yes ☐ No
Describe_____

PAYMENT IS EXPECTED AT THE TIME OF EACH VISIT! ☐ **CASH** ☐ **CHECK** ☐ **CREDIT CARD**

Are you insured? ☐ No ☐ Yes, Ins Company_____Policy #_____

Name of
Insured_____DOB_____SS#_____

I understand and agree that health and accident insurance policies are an agreement between an insurance co. and myself. Furthermore, I understand that Chiropractic Center of West Greenwich will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized be paid directly to Chiropractic Center of West Greenwich and be credited to my account on receipt. However, I clearly understand and agree that any services rendered to me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees from professional services rendered to me will be immediately due and payable.

PATIENT'S SIGNATURE_____ DATE _____

GUARDIAN OR SPOUSE'S SIGNATURE_____DATE_____