

Chiropractic Center of West Greenwich

SHERRY MORRISSETTE D.C., D.A.C.N.B, B.C.N. and JACOB MORAN D.C.

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	<input type="checkbox"/>	<input type="checkbox"/>	6. Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	11. Nervousness	<input type="checkbox"/>	<input type="checkbox"/>
2. Backaches	<input type="checkbox"/>	<input type="checkbox"/>	7. Headaches	<input type="checkbox"/>	<input type="checkbox"/>	12. Sinus Trouble	<input type="checkbox"/>	<input type="checkbox"/>
3. Heart Trouble	<input type="checkbox"/>	<input type="checkbox"/>	8. Asthma	<input type="checkbox"/>	<input type="checkbox"/>	13. Anemia	<input type="checkbox"/>	<input type="checkbox"/>
4. Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	9. Neuritis	<input type="checkbox"/>	<input type="checkbox"/>	14. Cancer	<input type="checkbox"/>	<input type="checkbox"/>
5. Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>	10. Digestive Dis	<input type="checkbox"/>	<input type="checkbox"/>			

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 _____