**Taylor Chiropractic Clinic**
1212 Buchholzer Blvd.
Cuyahoga Falls, OH 44221
(330) 928-2000

Patient ID # _____

Date _____

CONFIDENTIAL PATIENT INFORMATION

Social Security # _____

**Name** _____ **Home Phone** _____

Address _____ **City** _____ **State** _____ **Zip** _____

Age _____ **Birth Date** _____ **Marital Status:** ☐ Married ☐ Single ☐ Widowed ☐ Divorced # of Children _____

☐ **Male** ☐ **Female** **Height** _____ **Weight** _____ Email _____

**Race/Ethnicity:** ☐ Caucasian ☐ African American ☐ Asian American ☐ Hispanic/Latino ☐ Other _____

Occupation _____ Employer _____

Address _____ Office Phone _____

Name of Wife/Husband _____ Occupation _____

Employer _____ Office Phone _____

Patient's Nearest Relative _____ Address _____

Home Phone _____ Work Phone _____

Referred by _____

Who should we contact in case of emergency? _____ Phone _____

Date of Last Physical Examination _____ Family Physician _____

**Medications** _____ ☐ None

**Allergies** _____ ☐ None

**Tobacco Use** ☐ Yes ☐ No Frequency _____

Have you ever suffered from:

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

Reason for Appointment _____

Other Doctors seen for this Condition _____

Have you been treated for any health condition by a Physician in the last year? ☐ Yes ☐ No

Describe _____

Remarks and additional information _____

_____

PAYMENT IS EXPECTED AT THE TIME OF VISIT. Will you be paying today by: ☐ Cash ☐ Check ☐ Credit Card

Name of Person Responsible for Payment _____

Are You Insured? ☐ Yes ☐ No Company _____ Policy # _____

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that TAYLOR CHIROPRACTIC CLINIC will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to TAYLOR CHIROPRACTIC CLINIC will be credited to my account on receipt. However, I clearly understand and agree that any services rendered 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 for professional services rendered me will be immediately due and payable.

Patient's Signature _____ Date _____

Guardian or Spouse's Signature Date