Chiropractic Care Center
860-828-5503
3 Webster Sq Rd
Berlin, CT 06035

Date: _____ Dob:_____ Age_____

First Name_____ Middle Initial____ Last Name_____

City_____ ST _____ Zip_____

Home Phone _____ Cell_____ Email_____

Marital Status: ☐ Single ☐ Married ☐ Widowed ☐Divorced

Spouse Name: _____ Spouse Phone_____

Employer _____ Employer Phone_____

Emergency Contact Information Name Phone Relationship _____

Family Doctor _____ Date Last Physical _____

Referred by: _____

Check All Boxes That Apply

☐ ANEMIA ☐ ASTHMA ☐ BACKACHES ☐ BRONCHITIS

☐ CANCER/TYPE: _____ ☐ CHOLESTEROL ☐ DIABETES TYPE _____

☐ DIGESTIVE DISORER/TYPE:_____ ☐ DIZZYNESS ☐ HEADACHES

☐ HEART TROUBLE/TYPE:_____ ☐ HEPATITIS/TYPE_____

☐ HIGH BLOOD PRESSURE ☐ KIDNEY TROUBLES ☐ LYME DISEASE

☐ NEURITIS ☐ PACEMAKER ☐ PARKINSON'S ☐ RHEUMATIC FEVER

☐ SINUS PROBLEMS ☐ SMOKER/PACKS PER DAY/ YEARS _____

☐ SURGERIES/TYPE _____

☐ THYROID/TYPE _____ ☐ TURBERCULOSIS

ALLERGIES/TYPE/REACTION: _____

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What are your current symptoms? Work Related? Y N Auto Accident? Y N

What makes worse? _____

What makes better? _____

Other practitioners seen for this condition?

Payment and Insurance

Payment/Copay is due at time of visit unless other arrangements are made in advance.

Type of payment: ☐ Cash no insurance ☐ Insurance ☐ Workers Comp ☐AutoCollision

Insurance Company: _____

Policy Number_____ Group Number_____
Last 4 of Social Security _____
Secondary Insurance Policy
Insurance Company: _____

Policy Number_____ Group Number_____

Authorization

I hereby authorize payment directly to Carrie Hartney, DC of my medical benefits otherwise payable to me. I understand that I am financially responsible to the doctor for the deductible and co-pay amounts and they are due at time of visit. I authorize the Chiropractic Care Center, LLC to examine and treat me for my current medical condition.

I'm aware that after treatment there is often soreness and spasm following care. This is a part of the normal healing process.

Signature _____ Date_____