# MORAMARCO CHIROPRACTIC OFFICE, P.C.

3 Baldwin Green Common • Suite 204 • Woburn, MA 01801

**CONFIDENTIAL PATIENT INFORMATION**

## CONFIDENTIAL PATIENT INFORMATION

Patient Name_____ Today's Date_____
Address_____ City_____ State_____ Zip_____
Home Phone_____ Work Phone_____ Cell Phone_____
Email Address (for appointment reminders and holiday hours only, no junk)_____
Birth date_____ Age_____ Social Security Number_____
Marital Status M S D W # of Children_____ Occupation_____
Name of Employer_____ Have you had any previous chiropractic care? __Yes __No
Date of last physical exam_____

## HEALTH INFORMATION

What is your reason for today's visit? _____
Major Complaints _____
How long have you had this condition? _____
Have you had similar conditions in the past? □Yes □No
If yes explain_____
Is the condition interfering with your □sleep □work □daily routine
What aggravates this condition? _____ Helps condition _____
Have you seen other Doctors for this condition □Yes □No _____
Are you taking any medications □Yes □No (please list any medications)_____
Do you have a pacemaker □Yes □No Do you have a history of fainting □Yes □No
Have you had any surgery, falls or accidnts? □Yes □No Explain _____
Are you or do you suspect you may be pregnant? □Yes □No

## DO YOU SUFFER FROM

| | | | |
|---|---|---|---|
| □Headaches | □Tuberculosis | □Constipation | □Morning fatigue |
| □Neck Pain | □High/low blood pressure | □Diabetes | □Anemia |
| □Arm/ shoulder pain | □Prostrate disorder | □Swollen joints | □Poor memory |
| □Back pain | □Kidney problems | □Insomnia | □Hot Flashes |
| □Hip/ leg pain | □Bladder problems | □Dizziness | □Other _____ |
| □Chest pain | □Abdominal pain | □Numbness | |
| □Sinus trouble | □Asthma | □Nervousness | |
| □Heart trouble | □Gall bladder | □Depression | |

## INSURANCE INFORAMTION

Do you have health insurance? □Yes □No Company_____ ID# _____
Name of Insured (the subscriber) _____ Subscriber Date of Birth _____
Is this condition due to: □A work related injury □An automobile accident. If yes to either of these, please complete the reverse side of this form.

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that Moramarco Chiropractic Office will prepare any necessary forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to the Moramarco Chiropractic Office will be credited to my account on receipt. However, I clearly understand and agree that all 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 Signature _____ Date _____

Guardian or Spouse's signature: _____ Date _____