A-C Chiropractic Inc. Dr. Alan Cason 463 Hidden Creek Ln, Harrisonburg Va 22801 (540) 433-6909 Fax (540) 564-2989

NEW PATIENT INFORMATION

Please Print Date_____

Name_____ Preferred Name_____ Birthdate_____Age_____Sex_____

Address_____City,State, Zip_____

Home Phone_____ Email_____

Cell Phone_____ May we call your cell phone?_____ Do you use text messaging?_____

Occupation_____ Employed by_____ Work Phone_____

Address_____ May we call you at work? Yes No

May we leave a message on your answering machine and/or at work? _____

Married, Divorced, Single, or Widow Number of children_____ Spouse's Name_____

Emergency Contact not living with you_____ Phone_____

Address_____

How were you referred to our office?_____

Have you had chiropractic care before?_____If yes, when?_____

List chief complaints in order of severity:

1. _____ For how long?_____
2. _____ For how long?_____

List other doctors consulted for these conditions:

1. _____ Address_____
2. _____ Address_____

Is this injury or illness work related?_____Have you reported it to your employer?_____

Is this injury or illness related to an auto accident?_____ If yes, name of auto insurance co._____

Policy #_____ Claim #_____ Agent name_____

Address:_____

NOTICE: Not all patients require x-rays to determine or verify a diagnosis, type of treatment and length of treatment. If your examination warrants x-rays analysis the following policy prevails:

1. All first charges are payable when services rendered
2. The fee paid for treatment x-rays is for analysis only. The film itself is the property of this office. Once films are used for treatment purpose they cannot be released.

Method of payment you plan to use to take care of today's charges:

Check:_____Cash:_____MasterCard:_____Visa_____Discover_____ Other:_____

Do you have major medical insurance?_____ Name of Company_____

Are you covered under any other group or individual health policy through yourself or spouse?_____

If so, what company?_____Employer:_____

Patient Signature:_____