Back to Basics Chiropractic, P.L.L.C.
Confidential Health Information Questionnaire

Please Fill in All portions of this form that is applicable, if you are responsible and the insured the first part of the form is important.

Date: ______________________________ *Please sign and date the bottom of this form*

Patient Name: ____ **Date of Birth**: _______________

Age: __________ Sex: Female____ Male______ Email:___________________________________

Address: ____

City: ___________________State: ___________________Zip: _____________________

Home Phone: (______) ______________ Work Phone: (____)________________Cell:(______)_______________

SS#: _____________________Driver's License Number: ____________________

Name & Address of Employer (include city, state and zip code)

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Occupation:____

Marital Status: Married_________ Single________ Divorced_______ Widowed_________

Is this visit due to an Injury or Auto Accident?_____________If yes, we will need additional information.

****We will need to copy your insurance card****

Insurance Plan: ________________________________ Policy #: _________________________

Group # ____

Insured Name:_______________________________ Date of Birth:___________________

If you have a secondary policy, please let us copy your insurance card
If You Are the Insured only give us your Spouse's Name

Spouse Name: ____

Spouse's SS#:: ______________________Spouse's Date of Birth:_____________________

Work Phone: ________________ Day Phone: _________________________________

Spouse's Employer & Address:

____

Insurance Plan: ________________________________ Policy #: _________________________
Group # ____

If you are Responsible for this account, do not fill out.
Person Responsible for Account: ____
Relationship: ______________________
Address: ____
Work Phone: ________________ Day Phone: _________________________________
Driver's License Number: ____________________________
Social Security Number: ____
Employer: ________________________________ Occupation: ________________________________
Employer's Address:

____

Emergency Contact (Name & Tel #) ____

Who Referred you to this office?____

Signature/Patient-Guardian:____**Date:**_________________