JONES FAMILY CHIROPRACTIC PA 134 E. Peace St., Canton MS 39046

Name_____Date_____

Mailing Address_____City_____St_____Zip_____

Home Phone _____Cell Phone_____

Age_____ Birthdate_____DL#_____SS#_____

Email _____Gender (circle) M F Marital Status (circle) S M D W

Employer/Occupation_____Work phone_____

Name of Spouse _____Spouse SS# _____Spouse Birth date_____

Emergency Contact/Phone_____

Current Complaints:
Describe Complaints: _____

Date symptoms appeared: _____Is this an accident? YES____NO____ Date of Injury_____

Type of accident (circle) AUTO / Worker's Comp / Other Is PAIN getting WORSE BETTER SAME

List prior Treatments, X-rays, or MRI's _____
_____
_____
_____

List all past Surgeries and Hospitalizations _____
_____

Are you a Tobacco user? _____Smoker? _____Do you drink alcohol?_____

Are you PREGNANT or trying to become Pregnant? _____

Attorney Information (if applicable) Name: _____ Phone:_____

Insurance Information
Do you have health insurance? _____YES_____NO

Primary Insurance	Secondary/Supplement Insurance
Insurance Co. Name:	Insurance Co. Name:
Policy Holder Name:	Policy Holder Name:
Date of Birth:	Date of Birth:
ID/Member #:	ID/Member #:
Group#:	Group#:
Relationship:___self___spouse____child___other	RelationshiptoPatient:___self___spouse___child____other

Who can we THANK for referring you to our office? _____

List ANY **Medications** (Mandatory to fill out) Dosage Times Daily

List **Allergies** to any Medications Reactions Vitamins/Supplements

Family Health History (circle all that apply):

Mother	Neck/back pain, cancer, diabetes, heart problems, arthritis, MS, other _____
Father	Neck/back pain, cancer, diabetes, heart problems, arthritis, MS, other _____
Brother	Neck/back pain, cancer, diabetes, heart problems, arthritis, MS, other _____
Brother#2	Neck/back pain, cancer, diabetes, heart problems, arthritis, MS, other _____
Brother#3	Neck/back pain, cancer, diabetes, heart problems, arthritis, MS, other _____
Sister	Neck/back pain, cancer, diabetes, heart problems, arthritis, MS, other _____
Sister#2	Neck/back pain, cancer, diabetes, heart problems, arthritis, MS, other _____
Sister#3	Neck/back pain, cancer, diabetes, heart problems, arthritis, MS, other _____

Assignment & Release – By signing below, I authorize Jones Family Chiropractic PA to release medical records required by my insurance company(s). I authorize my insurance company(s) to pay benefits directly to Jones Family Chiropractic PA and I agree that a reproduced copy of this authorization will be as valid as the original. I understand that I am responsible for any amount not covered by my insurance, or any amount for a patient for which I am the guarantor. I agree that I will be responsible for any collection agency or attorney fees incurred. I understand that by signing below, I am giving written consent for the use and disclosure of protected health information for treatment, payment, and health care operations. If patient is a minor, by signing I give consent for examination, tests and procedures for the above minor patient.

Signed _____ Date _____