Welcome to our office!

Dr. Shan Tian, D. C.

Patient Information

Please complete all questions.

Today's Date: ________________________

Name: ____

Street: ____ Apt# _____________

City: ____________________________ State: ______ Zip: _________ Social Security #: _________________

Birth Date: _______________ Sex M ___ F___ Single ___Married ___Divorced ___Widowed ___Separated___

Email Address: _____________________ Home Phone: _______________ Cell/Other Phone: ____________

___Employed ___Full-Time Student ___Part-Time Student ___ Retired Patient's School Name _____________________

Patient Employer: ___________________________________ Occupation: ______________________________

Work Address: ____ Work Phone: _________________________

Name of spouse _________________________Spouse's Employer: ___________________________________

Names and Ages of Children ____

Who may we thank for referring you to our office? ____

In Case of Emergency, who should be notified? ____

Relationship to patient: __________________________________ Phone: _______________________________

INSURANCE INFORMATION

Responsible Party (if different from patient): ____

Relationship to Patient: __________________ Birth Date: ___________ Social Security#: _______________

Address: ____

City: ________________________________ State: ______ Zip: ____________ Phone: __________________

Responsible Party Employer: ________________________________ Work Phone: _______________________

Name of Insurance Company: ______________________________________ Phone: _____________________

Group/Policy#: _________________________ Contract/Subscriber#: __________________________________

Have you ever seen a chiropractor before? ____Yes ____No If so, when was last visit? _________________

Family Medical Doctor: ____

Address: ____ Phone: __________________

What surgeries have you had if any?

1) ____ When? ________________________

2) ____ When? ________________________

3) ____ When? ________________________

2007 Rainbow Drive Gadsden, AL 35901 Ph: 256-543-0009 Fax: 256-549-1221

Patient Name ______________________________

Have you experienced any of the following? Please circle yes or no. If yes, explain on the line following. If you need more room, please use the back of this form.

1. Falls ______________________________ Yes No
2. Sports injuries? ______________________________ Yes No
3. Broken bones? ______________________________ Yes No
4. Auto accidents? ______________________________ Yes No

   When? Any injuries? ______________________________

FAMILY/MEDICAL HISTORY

Father: Deceased? NO YES If yes, Cause of Death: ______________________________

Mother: Deceased? NO YES If yes, cause of Death: ______________________________

Brothers/Sisters: How many? __________ Significant health problems? ______________________________

Are you taking any medications? Please list. ______________________________

____

Are you now or have you suffered from any of the following? ___ Cancer ___ Stroke ___ Sinus

___ Shingles ___ Fatigue ___ Migraine/Headache ___ Dizziness ___ Anxiety ___ Fainting

___ Heart Problems ___ Respiratory Problems ___ Diabetes ___ Numbness ___ Arthritis

___ High Blood Pressure ___ Psychological Problems ___ Other______________________________

Pregnancy Release: This is to certify that to the best of my knowledge, I am not pregnant and the above doctor and her associates have my permission to perform an x-ray evaluation. I have been advised that x-ray can be hazardous to an unborn child.

____
Signature Date

Consent to treat a minor child: I hereby authorize this office to administer chiropractic as deemed necessary for my child.

____
Signature Date

Not all patients require x-rays to determine or verify a diagnosis, type of treatment or length of treatment; if your examination warrants x-ray analysis, the fees paid for x-rays is for analysis only and the film itself is the property of this office and must remain part of your permanent patient record.

ALL FIRST VISIT CHARGES ARE PAYABLE WHEN SERVICES ARE RENDERED. I CLEARLY UNDERSTAND AND AGREE THAT I AM PERSONALLY RESPONSIBLE FOR PAYMENT.

I have read and completed the above information.

____
Signature Date

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