

**Welcome to Schreffler Chiropractic  
Keith Schreffler, D.C**

**Patient Information Form**

Name \_\_\_\_\_ Date \_\_\_\_\_ e-mail \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Phone(H) \_\_\_\_\_ (W) \_\_\_\_\_ (Cell) \_\_\_\_\_ Emergency \_\_\_\_\_

Age \_\_\_\_\_ Sex ( M ) ( F ) DOB: \_\_\_\_\_ Marital Status ( S M W D ) Spouse's Name \_\_\_\_\_

Employer \_\_\_\_\_ Occupation \_\_\_\_\_

Referred By \_\_\_\_\_ Person Responsible for this Account \_\_\_\_\_

**Primary Health Insurance**

Insurance Company \_\_\_\_\_ Policy ID # \_\_\_\_\_

Group # \_\_\_\_\_ Ins. Co. Phone \_\_\_\_\_ Ins. Co. Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

**Patient Active Problems:**

What is your major complaint? \_\_\_\_\_

Date symptoms appeared \_\_\_\_\_ Have you had these symptoms before? ( Y / N ) if Yes, when \_\_\_\_\_

Is this condition due to an A) auto accident B) work injury C) other accident D) unknown cause E) illness F) other \_\_\_\_\_

Are the symptoms: A) improving B) getting worse C) about the same D) intermittent

Circle any activities, which aggravate your condition:

A) Standing B) walking C) sitting D) lying E) bending F) lifting G) twisting H) coughing I) other \_\_\_\_\_

Have you seen another doctor for this condition? A) M.D B) Chiropractor C) Acupuncturist D) Podiatrist E) other \_\_\_\_\_

Dr. Name \_\_\_\_\_ Date Consulted \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Diagnosis \_\_\_\_\_

**Please Note: A \$30 charge will be assessed for missed/canceled appointments with less than a 12 hour notice.**

I, \_\_\_\_\_ hereby authorize Keith Schreffler, D.C. to apply for benefits on my behalf for covered services rendered by him. I authorize payment from my insurance company be made directly to Keith Schreffler D.C. I further certify that the information reported with regard to my insurance company is correct. If the insurance information provided herein is incorrect, I understand that I am fully liable for accrued charges and must make payment within 30 days or legal action can be taken against me for insurance fraud I further authorize release of necessary information and permit that a copy of this authorization be used in place of the original. I further understand that I may be responsible for payment of any services rendered which are not covered by my insurance plan(s). My insurance company or I may revoke this authorization.

Signature \_\_\_\_\_ Date \_\_\_\_\_