New Patient Form
Wignall-Kennedy Chiropractic

Confidential Patient Information **Date:_____**
Instructions: Please Print

Name:_____ Sex: M___ F___ Age:___ Birthdate:__/__/____
(First) (Middle Initial) (Last)
Address:_____ City:_____ Zip Code:_____

Marital Status: M S W D Cell Phone:_____ Home Phone:_____

Occupation:_____ Where Employed:_____

Spouse's Name:_____ Spouse's Employer:_____

Spouse's Birthdate:__/__/____

Please list below your main complaints in order of importance:
1._____ How Long:_____ 2._____ How Long:_____

3._____ How Long:_____ 4._____ How Long:_____

Have you seen other Doctors for this condition? YES_____ NO_____

Have you been treated for a health condition by a physician in the last year? YES____ NO____

Describe:_____

What medications or drugs are you currently taking? _____

_____

Previous Chiropractor: _____ Medical Doctor:_____

Other:_____

List any surgeries you've had:_____ When:_____

List any injuries you've had:_____ When:_____

Family History:_____
_____

(Please list any family illness such as; tuberculosis, cancer, diabetes, high blood pressure, etc)

Female History
Date of last cycle:__/__/____ Regular:_____ Irregular:_____ Birth Control: YES____ NO____

Are you pregnant: YES____ NO____ Date:__/__/____ Signature:_____

PAYMENT EXPECTED AT TIME OF VISIT!
Are you insured: YES____ NO____ Name of Company:_____

Is your spouse insured: YES____ NO____ Name of Company:_____

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that Dr. Kennedy's office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to Dr. Kennedy will be credited to my account on receipt. However, I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payments. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered me will be immediately due and payable.

ON ALL INSURANCE ASSIGNMENTS, DEDUCTIBLES MUST BE MET IN THE BEGINNING.

I request and consent to the performance of chiropractic adjustments and other chiropractic procedures and diagnostic x-rays by Dr. Kennedy and his staff.

Patient's Signature:_____ SS#:_____-_____-_____ Date:__/__/____