Arlington Natural Wellness Center

CONFIDENTIAL PATIENT INFORMATION FORM

Please fill out *ALL* information.
(PLEASE PRINT) Today's Date_____ Referred by _____
Last Name_____ First Name_____ Middle Initial_____
Home Address_____
City_____ State_____ Zip Code_____ Home Phone (_____)_____
Age_____ Date of birth ____/____/____ Sex: ☐male ☐female Driver's License #_____
Martial Status: ☐Single ☐Married ☐Divorced ☐Widowed Spouse's name_____
Occupation_____ Employer Name_____ Work Phone (_____)_____
Social Security #_____Guardian Soc. Sec. # (if patient under 18 years of age) _____
Person responsible for account_____ Relationship to patient_____
Person to contact in case of emergency_____
Address_____ Phone (____)_____
Patient Email address _____@_____ Patient Cell Phone (____)_____

Date of last physical exam_____ Doctor's name/type_____
Reported findings_____
Has your back or neck been x-rayed less than 3 years ago? _____ Where? _____
List all surgeries / serious illness / hospitalizations (include years in brackets):
_____
_____
List all broken bones / dislocations / major dental work (include years in brackets):
_____
_____
Have you ever suffered from?

☐Dizziness	☐Arthritis	☐Tuberculosis	☐Heart Trouble	☐Cancer
☐Headaches	☐Numbness	☐Breathing Problems	☐Diabetes	☐Venereal Disease
☐Sinus Trouble	☐Neuritis	☐Asthma	☐Rheumatic Fever	
☐Backache	☐Nervousness	☐Digestive Disorders	☐Anemia	

What is your current major complaint? _____
_____
How long have you had this condition? _____
Have you have had this or similar conditions before? ☐Yes ☐No
What activities aggravate your condition? _____; Improves your condition? _____
Is this condition becoming progressively worse? ☐Yes ☐No ☐The Same
Status of your condition? ☐Constant ☐Comes and goes
This condition interferes with (check all that apply): ☐Work ☐Sleep ☐Daily Routine ☐Other_____
List previous diagnosis / treatments you have received for this condition:
_____
Any additional complaints? _____
_____
What current medications/drugs are you taking (state reasons in brackets following drug):
_____
_____
_____

Do you have insurance? ☐ Yes ☐ No Insurance Company name_____
Is this a work-related injury? ☐Yes ☐No; If Yes, is this your first Dr.'s visit? ☐Yes ☐No

I hereby give my consent to Arlington Natural Wellness Center (Brian T. Hickey, DC) to provide services to myself and / or family. I understand that there is a fee for services, and that ***fees are payable at the time services are rendered***. I hereby agree to such fees, and understand that I am liable for any and all legal fees if collection services become necessary.

Responsible Party/Patient_____Date_____

For Insurance/Worker's Compensation filing: I authorize the release of any medical or other information necessary to process claims. I also request payment of medical benefits Brian T. Hickey, DC for services rendered.

Signature of Insured _____ Date_____