CCC Application for Care

***Patient Name**: ____ Today's Date: ___/___/___

Social Security Number __________________________ ***Birth Date:** ___/___/___ ***Age:** _______ ***Gender:** F M

Height: ______________ Weight: _____________ ☐ Left Hand ☐ Right Hand

Women: Are you currently pregnant? ☐ Y ☐ N ☐ Uncertain

This section is for individuals under the age of 18 years of age. Please fill in the correct information for the parent(s) or guardian(s).

Father: ____________________________ Date of Birth: ___/___/___ Phone: (_____) ___________________

Mother: ___________________________ Date of Birth: ___/___/___ Phone: (_____) ___________________

Guardian: __________________________ Date of Birth: ___/___/___ Phone: (_____) ___________________

Who do you normally live with? ☐ Mother and Father ☐ Father ☐ Mother ☐ Legal Guardian

☐ None of these

***Marital Status:** ☐ Married ☐ Separated ☐ Widowed ☐ Single How many children? __________

PATIENT'S CURRENT ADDRESS:

Street: ____

City: ____ State: ______ Zip: __________

***Primary Phone:** (______) _______________ ***H-Phone:** (______) _______________

***C-Phone:** (______) ______________ ***E-mail:** ____

Your Occupation: _____________________________ Employer: _________________________________

Work Address: ____

Work Phone: (_____) _____________

Student at: ____ ☐ FULL-TIME ☐ PART-TIME

Spouse Information:

Name of Spouse: ____***Spouse's Date of Birth**: ___/___/___

Spouse Address: ☐ *Check box if same as patient's address.*

Street: ____

City: ____ State: ______ Zip: __________

***Primary Phone:** (______) _______________ ***H-Phone:** (______) _______________

***C-Phone:** (______) ______________ ***E-mail:** ____

Spouse's Occupation: ________________________________ Spouse's Employer: ___________________________

Spouse's Work Address: ____ ______________________________

Work Phone: (_____) _____________

Spouse is a student at ____ ☐ FULL-TIME ☐ PART-TIME

Emergency Contact Information:

Name: __________________________________ DOB: _________________________

Primary E-mail: ____ Phone (_____) __________________

***How did you learn about us OR who can we thank for referring you to us?** _______________________________

***When was your last visit to a chiropractor?** ____

Is your condition or injury due to an accident or work-related cause? ☐ YES ☐ NO

**Please check ALL that apply:

Did the condition or injury result from *automobile* accident? ☐ YES ☐ NO

Did it result from a *work-related* accident or cause? ☐ YES ☐ NO (briefly describe) __________________

____

If the condition did not result from an automobile accident or relate to your work, where did the accident occur? ____

Do you have health insurance? ☐ YES ☐ NO ☐ Not Sure

Company: ____

Full Name of Policy Holder: ____________________________ Policy Holder's Date of Birth ___/___/____

Does the policy holder have the insurance through his/her employer? ☐ YES ☐ NO

If yes, who is the employer? ______________________________

Method of payment for visit: Cash _______ Check ______ Credit Card_____

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Carbondale Chiropractic Center
Family & Sports Chiropractic
267 Brooklyn Street, Suite A
Carbondale, PA 18407
P: 570-282-1240 / F: 570-282-7937