

Weis Chiropractic Health Center
CONFIDENTIAL New PATIENT INFORMATION FORM
10671 McSwain Drive
Cincinnati, OH 45241
Voice: 513.563.0414 FAX 513.563.9540 Web: www.weischiro.com

Instructions

The information on this document is kept in your confidential patient file in our office as a record of your office visit.

After printing the document, please fill it out completely. Bring the completed and signed document with you to your office visit. By doing so you'll be able to speed up the initial registration process as a new patient.

Patient Details

Last Name: _____ **First Name:** _____ **Middle:** _____
Marital Status: Married Single Divorced Widowed
Birth Date: ___/___/___ **SSAN:** _____/_____/_____
Address: _____ **Phone:** _____
City: _____ **State:** _____ **Zip Code:** _____
Email Address: _____ **Occupation:** _____
Employer Name: _____
Employer Address: _____
City: _____ **State:** _____ **Zip Code:** _____
Telephone: _____
Name of Spouse (parent, if you are a minor): _____ **Phone:** _____
Primary Care Physician: _____ **Phone:** _____
Insurance Provider: _____ **Phone:** _____ **ID#:** _____

Visit Details

Chief Complaint: _____
Date Problem Started: _____ **Auto Accident Related:** Yes No **Work Related:** Yes No
Since your last visit have you required surgery or hospitalization? Yes No **If yes, please explain briefly the details:** _____
Since your last visit have you required treatment from another physician? Yes No **If yes please explain briefly the details:** _____
Do you suspect that you may be pregnant? Yes No
Are you currently taking any over the counter medications? Yes No **Explain:** _____
Are you currently taking medications for the following: Anti-inflammatory Muscle Relaxants Birth Control
Blood Thinners High Blood Pressure Pain Relievers
Other Explain: _____
Have you ever been diagnosed with: High Blood Pressure Heart Attack Emphysema Seizures/Convulsions
Thyroid Disease Circulation Problems Cancer (if yes, please describe type of cancer: _____
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Please note: payment or insurance co-payment is expected at time of visit.

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Patient Signature / Date