



Zimmerman Chiropractic Clinic
7 East Main Street
DuQuoin, IL 62832
(618) 542-2165

Today's Date _____

Registration

Patient Information

_____		_____	
(First, Middle, Last Name)		(Date of Birth)	
_____		_____	
(Address)		(City, State, Zip Code)	
_____	_____	_____	_____
(Home Telephone Number)	(Work Telephone Number)	(Social Security Number)	(E-mail)
Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed			
Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female			
Employment Status: <input type="checkbox"/> Employed <input type="checkbox"/> Part-time Student <input type="checkbox"/> Full-time Student <input type="checkbox"/> Other			

Employment Information

_____		_____	
(Occupation)		(Employer)	
_____		_____	
(Address)		(City, State, Zip)	

Spouse Information

_____		_____	
(Name)		(Date of Birth)	
_____		_____	
(Social Security Number)		(Occupation)	
_____		_____	
(Employer)		(Employer Phone Number)	

Responsible Person (If Applicable)

_____		_____	_____
(Name)		(Date of Birth)	(Relationship to Patient)
_____		_____	
(Address)		(City, State, Zip Code)	
_____	_____	_____	
(Phone Number)	(Social Security Number)	(Occupation)	
_____		_____	
(Employer)		(Employer Phone Number)	

Relative to Contact in Case of Emergency (Not Living in Home of Patient)

_____		_____	_____
(Name)		(Phone Number)	(Relationship to Patient)
_____		_____	
(Address)		(City, State, Zip Code)	

Treatment History

Have you ever been treated by a Chiropractor before? If yes, list doctor(s) _____

Have you been treated by any other doctors for your current complaint? If yes, list doctor(s) _____

Have you ever had any accident or injury? If yes, list years and describe event(s) _____

Medical History

Have you ever had any surgeries? If yes, List year and type of surgery _____

Do you currently take any medication (prescription or over the counter) on a regular basis? If yes, list medicine and how often it is taken _____

Are you pregnant? _____ Do you have a pacemaker? _____ Are you Diabetic? _____

Past medical conditions _____

How many children do you have? _____ How many hours do you work in an Average week? _____

Do you exercise regularly? If yes, list type of exercise and how often _____

Medical Doctor Name: _____

How were you referred to our office?

- By an Attorney
- By a Doctor
- By a Patient
- Other

Please print the name of your source below.

Is your illness or injury related to any of the following?

- Employment
- Emergency
- Accident
- Auto Accident

If Auto Accident, please print the state where the accident occurred below

Consent to Treatment/ Financial Responsibility and Assignment of Benefits
I voluntarily consent to receive medical and health care services that may include diagnostic procedures, examination, and treatment.

I hereby assign, transfer, and set over to Zimmerman Chiropractic all of my rights, title, and interest to my medical reimbursement benefits under my insurance policy. I authorize the release of any medical information needed to determine these benefits. This authorization shall remain valid until written notice is given by me revoking said authorization. I understand that I am financially responsible for all charges whether or not they are covered by insurance notice is given by me revoking said authorization. I understand that I am financially responsible for all charges whether or not they are covered by insurance notice is given by me revoking said authorization. I understand that I am financially responsible for all charges whether or not they are covered by insurance.

I certify that I have read this form and understand its contents.

Patient or other legally authorized person: _____