# ALDANA CHIROPRACTIC
# NEW PATIENT INTAKE FORM

DATE: _____

First Name_____ Last Name _____ Date of Visit _____

Address _____ Time of Visit _____

_____ Provider _____

Cell Phone _____ Home Phone _____

Date of Birth _____ Email _____

How did you hear about us? _____

What is your major complaint? _____

When did it start? _____

Have you seen another doctor concerning this condition? YES ____ NO ____

If yes, name of doctor and office _____

Have you been injured? (Circle if applicable) In an auto accident/On the job Date: _____

**HEALTH INSURANCE**

Do you have medical insurance? YES____ NO____

Do you have Medicare: YES____ NO____

Insurance Company _____ Type: PPO____ HMO____ POS___

ID # _____ Group # _____ DOB _____

Phone # _____ Policy Holder Name _____

Do you have secondary insurance? YES____ NO____

Do you have Medicare: YES____ NO____

Insurance Company _____ Type: PPO____ HMO____ POS___

ID # _____ Group # _____ DOB _____

Phone # _____ Policy Holder Name _____

Do you have HSA (Health Savings Account) or HRA (health Reimbursement Account (Circle)