Longner Chiropractic

"Dedicated to getting sick people well, and keeping them that way."

Please Print

NAME: FIRST _____ LAST _____ MI _____

MAILING ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

PHYSICAL ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

HOME PHONE: (____) ____ - _____ WORK PHONE: (____) ____ - _____

CELL PHONE: (____) ____ - _____ EMAIL ADDRESS: _____

BIRTH DATE: _____ SOCIAL SECURITY #: ____ - ____ - _____

OCCUPATION: _____ EMPLOYER: _____

SPOUSE'S NAME: _____ BIRTH DATE: _____ SOCIAL SECURITY#: ____ - ____ - _____

REFERRED TO THIS OFFICE BY: _____

PRESENT COMPLAINT: _____

DATE OF INJURY: _____ WORK OR AUTO RELATED? YES ☐ NO ☐

DO YOU HAVE INSURANCE? YES ☐ NO ☐ INSURANCE COMPANY NAME: _____

GROUP#: _____ POLICY#: _____

PLEASE NOTE THAT WE WILL BILL YOUR INSURANCE COMPANY AS A COURTESY TO YOU.
YOU WILL BE RESPONSIBLE FOR PAYMENT IN THE EVENT THAT YOUR INSURANCE COMPANY FAILS TO MAKE TIMELY AND/OR PROPER PAYMENT.
PATIENTS ARE RESPONSIBLE FOR ANY ITEMS ISSUED AND NOT COVERED BY THE INSURANCE COMPANY AND FOR THE YEARLY DEDUCTABLE IF APPLIED TO ANY OFFICE VISIT RECEIEVED HERE.
WITH MY SIGNATURE, I HEREBY STATE THAT ALL OF THE ABOVE INFORMATION WAS TRUTHFUL AND ACCURATE.
I HAVE READ AND FULLY UNDERSTAND THE ABOVE INFORMATION.

SIGNED _____ **DATE** _____

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Write the corresponding letter directly on the area where you feel the pain.

NAME: _____ DATE: _____

A= ACHE **B=BURNING** **N=NUMBNESS**

P= PINS& NEEDLES **S=STABBING** **T= TINGLING**

O=OTHER