Sussex Chiropractic and Wellness Center
www.sussexchiropractic.com ♦ N63 W23524 Silver Spring Drive, Suite 4 ♦ Phone: (262) 246 – 8811
Sussex, WI 53089

Confidential Patient Information

Personal Information:

Patient Name (First, Middle, Last): _____

Address: _____

City, State, Zip: _____

Phone: Home: _____ Cell: _____ Work: _____

E-mail: Home: _____ Work: _____

Preferred Way to contact you (please check): ☐ Phone: ___ Home ___ Cell ___ Work

☐ Email: ___ Home ___ Work

Birth date: _____ Age: _____ Gender: ☐ Male ☐ Female

Social Security Number: _____

Emergency Contact: By providing emergency contact information, I authorize this office to contact the person I have listed in an emergency situation. I also authorize this office to obtain and share information with this party as it relates to the best interest of my care and treatment under the circumstances at that time.

Name: _____ Relationship to you: _____

Phone: Home: _____

Cell: _____

Work: _____

The Health Care Reform Bill passed by the Federal Government requires certain statistical information to be collected on all persons, including:

Primary Language You Speak: _____

Race (ie. Hispanic, Caucasion, etc.): _____

Ethnicity (ie. Scottish, Italian, etc): _____

Marital Status: ☐ Single ☐ Married Name of Spouse: _____

☐ Legally Separated ☐ Divorced ☐ Widowed Number of Children: _____

Occupational / Employment Information:

☐ Currently employed: Occupation: _____

Company: _____

Phone: _____

☐ Retired: Previous Occupation: _____

☐ Other: _____

I understand that I have certain rights to privacy regarding my protected health information and that this information can and will be used to:

* *conduct, plan and direct my treatment and follow-up among the healthcare providers who may be directly and indirectly involved in providing my treatment;*
* *obtain payment from third-party payors;*
* *conduct normal healthcare operations such as quality assessments and accreditation.*

_____ _____

Signature of Patient/ Parent or Guardian *Date*

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Confidential Patient Information

Patient Name: _____ Date of Birth: _____
Please Print (First, MI, Last)

Primary Physician: _____

Facility/Clinic: _____ Phone: _____

Date of Last Physical: _____ Height: _____ Weight: _____ Blood Pressure: _____

Allergies: _____

Medications/Supplements (Please list below):

	Name (please print)	Dosage	Taken How Often
Prescriptions:	_____	_____	_____
	_____	_____	_____
	_____	_____	_____
	_____	_____	_____
Over The Counter:	_____	_____	_____
	_____	_____	_____
	_____	_____	_____
Vitamins/Supplements:	_____	_____	_____
	_____	_____	_____
	_____	_____	_____

Past Significant Health Matters Over the Last 5 Years (Please list with estimated date of occurrence):

Injuries: _____

Hospitalizations:_____

Surgeries: _____

Social History:

What are some of your leisure activities? _____

How would you rate your diet/eating habits? □ great □ good □ fair □ poor / needs improvement

Are you pregnant? □ NA □ no □ yes if yes, how far along are you? _____

I authorize the doctor to release all information necessary to communicate with personal physicians and other healthcare providers and payors, and to secure the payment of benefits. I understand and agree to allow this chiropractic office to use my Patient Health Information (PHI) for the purpose of treatment, payment, healthcare operations and coordination of care.

_____ _____

Signature of Patient / Parent or Guardian *Date*