

World Wide Wellness
PATIENT INTRODUCTION FORM

Today's Date: _____, 20____

Name: _____ SS# _____

Address: _____ Apt# _____

City: _____ State: _____ Zip: _____ Gender: (M) (F) Date of Birth: ____/____/____

HMPHONE(____) _____ WKPHONE(____) _____ CELLPHONE:(____) _____

Occupation: _____ Employer: _____ EMAIL: _____

Head of Household?(Y)(N) Number of Children: _____ Marital Status: (M) (S) (D) (W) (O)

Spouse's Name: _____ WkPhone(____) _____ CellPhone: (____) _____

Activities/Sports/Hobbies: _____

Guardian's Name (if under 18) _____ Phone(____) _____

Have you seen a Chiropractor before?(Y)(N) Whom may we thank for referring you? _____

IN CASE OF EMERGENCY

Nearest Relative not living with you: _____ Phone: (____) _____ Relationship: _____

Contact that is not a relative: _____ Phone: (____) _____ Relationship: _____

Primary Care Physician: _____ Office Phone: (____) _____

Address: _____ City: _____ State: _____ Zip: _____

MEDICAL HISTORY

(Check all that apply, past or present symptoms)

- | | | |
|--|---|---|
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Stress | <input type="checkbox"/> Asthma |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Joint Pain | <input type="checkbox"/> Dizziness |
| <input type="checkbox"/> Leg Cramps | <input type="checkbox"/> Neck Pain | <input type="checkbox"/> Upper Backaches |
| <input type="checkbox"/> Weakness of Limbs | <input type="checkbox"/> Lower Backaches | <input type="checkbox"/> Nervousness |
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Fatigue (A.M.)(P.M.) | <input type="checkbox"/> Digestive Problems |
| | | <input type="checkbox"/> Stiff Neck |

Are you tired when you wake up? (Y)(N)

Pain Level(1-best)(2)(3)(4)(5)(6)(7)(8)(9)(10-worst)

Are you taking any medications? List: _____

List any accidents/traumas/surgeries: _____

Any others not listed above? _____

Is there a family history of: Cancer Heart Disease Diabetes Other: _____

Females: Are you pregnant? (Y)(N)

Do you have health insurance? (Y)(N) Company? _____

Insurance Customer Service #(____) _____ Policy ID# _____

****Please read the following carefully and sign that you understand and agree to the terms listed below.****

Please initial by each line and sign at the bottom

I have read and understand the financial policy statement of World Wide Wellness and World Wide Wellness has my full compliance.

I authorize the release of any information pertinent to my case to any insurance company or adjuster for purposes of obtaining payment for my bills.

I further authorize and direct my insurance company, listed above, to pay World Wide Wellness directly for services rendered to me at PO Box 49188 Atlanta, GA 30359

In case of insurance, I understand that WWW submits my claims to my carrier as a courtesy to me, the patient.

Furthermore, I understand that whatever amounts are not collected from insurance, I personally owe this office in full.

I understand that in the event of a returned check a \$55 returned check fee will apply.

I also acknowledge that I have received and read the notice of privacy practices.

Patient Signature: _____ Date: _____, 20____

If patient is a minor: I hereby give my consent and permission for _____ to be treated in this office and furthermore agree to the above aforementioned.

Parent/Guardian's Signature: _____ Date: _____, 20____