ADVANCED HEALTH & PAIN CENTER

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301 NORTH 200 EAST - SUITE 1D, ST. GEORGE, UT 84770
TELEPHONE: (435) 652-8380 - FAX (435) 674-5919

WELCOME

Please present your Drivers License and Insurance Cards (if applicable) to copy.
Thank you for choosing our practice for your chiropractic needs. Please complete this form in ink.
If you have any questions or concerns, do not hesitate to ask for assistance. We will be happy to help.

PATIENT INFORMATION

Please PRINT

Last Name: ______________________ SS No.: ______________________

First Name: ______________ MI: ______

Address: ______________________

____

City: ______________________

State: ______________ Zip: ______________

Home Phone: ______________ Ext'n: ______________

Cell Phone: ______________________

Birth Date: ______________ Age: ______________

Gender:
- ☐ Male
- ☐ Female

Marital Status:
- ☐ Minor
- ☐ Widowed
- ☐ Married
- ☐ Single
- ☐ Divorced
- ☐ Separated

Do you prefer appt. reminders by ( ) Text ( ) Phone Call

Email Address ______________________

Your Employer: ______________ Occupation: ______________

Employer's Address: ______________ City: ______________ State: ______ Zip: ______

Spouse's or Parent's name: ______________ Work Phone: ______________

Person to contact in case of an emergency: ______________ Phone: ______________

Whom may we thank for your referral: ______________________

RESPONSIBLE PARTY

Please PRINT

Name of person responsible for this account? ______________________

Relationship to patient: ______________ Phone: ______________

Address: ______________ City: ______________ State: ______ Zip: ______

Name of Employer: ______________ Work Phone: ______________

INSURANCE INFORMATION

Please PRINT

Name of insured: ______________ Relationship to Patient: ______________

Birth Date: ______________ SS No if insured: ______________

Insurance Co.: ______________ Group No.: ______________

Address: ______________ City: ______________ State: ______ Zip: ______

DO YOU HAVE ADDITIONAL INSURANCE: ☐Yes ☐ No IF SO, PLEASE COMPLETE THE FOLLOWING:

Name of insured: ______________ SS No of insured: ______________

Insurance Co.: ______________ Group No.: ______________

Address: ______________ City: ______________ State: ______ Zip: ______

Symptoms

Name______________________________

PLEASE DESCRIBE THE REASON FOR YOUR VISIT **Rate Your Symptoms (1-10)**

1.____ ________
2.____ ________
3____ ________
4.____ ________
5.____ ________
6.____ ________

Symptoms developed from ☐ Job Related Injury ☐ Auto Accident ☐ Other Accident
☐ Illness ☐ Unknown
Date Problem Began______________________________________
Name and address of other doctor(s) who have treated you for your condition:__________________
____
____
Are you taking any medications: Yes ☐ No ☐ If Yes, what kind?______________________________
Women-Are you pregnant? Yes ☐ No ☐
What type of exercise do you perform on a daily basis? ☐ None ☐ Moderate ☐ Heavy
What kind of vitamins/nutritional supplements do you take if any?___________________________
____

Health History

Dates of last exams:____

Past Surgeries:____

Prior Accidents:____