Patient Information Case History
Please PRINT CLEARLY

Date: ______________ Doctor: Dr.Chandler George, D.C.

Name: ______________________________ Social Security #: _____-_____-_______

Address: _______________________________ City: ___________________ State: ________ Zip: ________

Home Phone: ______________ Work Phone: _______________ Cell Phone: _____________ Fax: __________

E-mail Address: ______________________________ Age: ________ Birthdate: ____/____/_____

Sex: M F Race: ___________ Marital: M S W D How many Children?__________

Occupation: _______________________ Employer: ____

Employer's Address: ___________________________ Office Phone: ________________________________
Spouse Name: __________________ Spouse Occupation: _________________ Employer_________________
Name of Nearest Relative: _____________________ Address: ____________________ Phone: ____________
How were you referred to our office? ____
Family Medical Doctor: ____________________________ Phone: ___________________________________

Please check any and all insurance coverage that may be applicable in this case.

☐ Major Medical ☐ Worker's Compensation ☐ Medicaid

☐ Medicare ☐ Auto Accident ☐ Other __________________

Name of Primary Insurance Company: _____________________________________ Phone#: _____________
Name of Primary card holder(if not patient above): ___________________________Birthdate:____/___/____
Group #: ___________________ ID: ____________________________ SSN#: _________________________

Name of Secondary Insurance (if any): _____________________________________ Phone#: ____________
Name of Primary card holder(if not patient above): ___________________________Birthdate:____/___/____
Group #: ___________________ ID: ____________________________ SSN#: _________________________

Purpose of this appointment: ____
Date symptoms appeared or accident happened?___________________________
Have you ever had the same or a similar condition? ☐ Yes ☐ No If yes, when and describe: ____________
____

Days lost from work: _______________ Date of last physical examination: ________________
What surgeries have you had? (include dates): ____
____

Serious illnesses (include dates): ____
____

Have you been treated for any health conditions by a physician in the last year? ? ☐ Yes ☐ No
If yes, describe: ____
____

What medications, drugs, or vitamin supplements are you taking? ____________________________________
____