Dr. Shannon Spence
Phone 402-371-9366
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www.SpenceChiro.com

107 N. 29th Street
Norfolk, NE 68701

Patient Information

Name: ______________________ Birthday: __________ Sex: M / F SS#: ______________

Current Address: __________________ Po Box ______ City: ____________ State: _____ Zip: ________

Home Phone: ______________ Cell Phone: ________________ Marital Status: ______________

Employment Status: Employed / Student / Retired / Unemployed / Homemaker Pregnant? Y /N Due: __________

Employer: ____________________ Occupation: ______________ Work Phone: ______________

Emergency Contact: _________________ Relationship: ____________ Phone: ______________

How did you hear about us? ○ Internet ○Radio ○Newspaper ○Phonebook ○ Referred by ______________

Primary Insurance

○ Same as Patient

Person Responsible for Account: ____________________ Relationship to Patient______________

Address: ____________________ Po Box: _____ City: ______________ State: ____ Zip: __________

Responsible Party Cell Phone: ______________ Responsible Party Employed By: ____________________

Insured's DOB: __________ Insured's SS#: ______________ Secondary Insurance: __________________

- I understand that I am legally responsible for payment of all charges, whether or not paid by insurance. I will be responsible for any co-payments, deductibles or non-covered items at the time services are rendered. I understand that if this account is not paid and no financial arrangements have been made, I will be responsible for collection fees, legal fees, service charges and any other expenses that are incurred in collecting this account.
- I authorize the staff to perform any necessary services needed during diagnosis and treatment. I also authorize the provider to release any information required to process insurance claims. I understand that I have the right to review your Notice of Privacy Practices and that this office complies with HIPPA guidelines.

Patient's Signature: ____________________________ Date: ____________

Parent / Guardian Signature Authorizing Care: ____________________ Date: ___________

SPENCE CHIROPRACTIC

Reason For Visit

Reason for today's visit: O Emergency O New Injury O Old Injury O Chronic Pain O Wellness

Are you in pain: Y / N Rate your pain on the following scale: 1 2 3 4 5 6 7 8 9 10

Did your injury occur during: O Work O Sports/Play O Auto Accident O Routine/Household Activity

Date condition/accident started? ____________ Where did your injury occur? ______________________________

Please explain what happened: ____

Symptoms (please check all that apply): O Pain O Numbness O Spasm O Tenderness O Constant

O Comes & Goes O Travels O Sharp O Dull

Previous Chiropractic Care? Y/ N

Clinic or Dr's name:

____

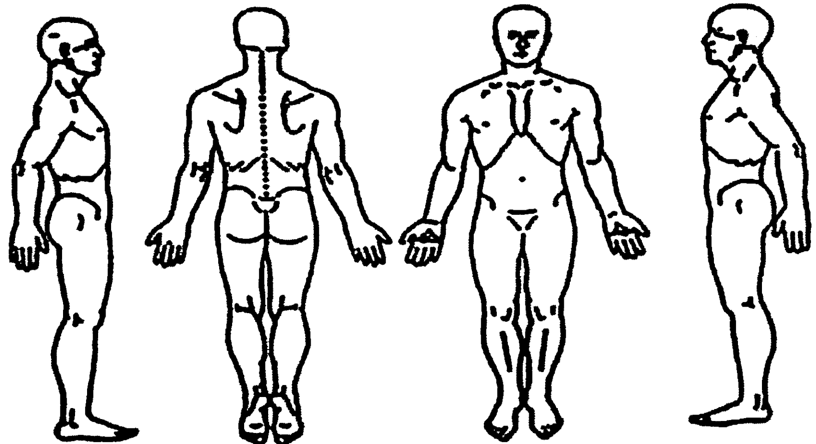
Any previous surgeries or

Illness to the neck or back? Y / N

If Yes, then describe: ________

____

Please Mark Pain Areas



- I guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform the office of any changes to my medical, personal and insurance information.
- I guarantee that I am the patient, the patient's guarantor or authorized to execute the agreements listed on this form and accept all terms.

Patient's Printed Name: ______________________________

Patient or Guardian Signature: _________________________________ Date: ________________