



Welcome to Brodows Chiropractic & Wellness Center

2606 Harwood Road

Bedford, TX 76021

817-540-1500

wellness@brodowschiropractic.com

www.brodowschiropractic.com

Date _____

Confidential Patient Information

Name _____ Social Security Number _____

Street Address _____ City _____ State _____ Zip _____

Cell Phone _____ Daytime Phone _____ Evening Phone _____

Email Address _____ Age _____ Birth Date _____

Marital Status: Married/Single/Widowed/Divorced Number of Children _____

Occupation _____ Employer _____

Employer Address _____

Employer Phone _____

Emergency Contact _____ Relationship to patient _____

Emergency Phone Number _____

I was referred to Brodows Chiropractic by: _____

Purpose of this appointment _____

Have you seen any other doctors for this condition? _____

Have you been treated by any health providers in the last year? yes no

Describe _____

Have you ever suffered from any of the following? (check all that apply)

- | | | |
|--|--|--|
| <input type="checkbox"/> Dizziness/Vertigo | <input type="checkbox"/> Headaches/Migraines | <input type="checkbox"/> Digestive Disorders |
| <input type="checkbox"/> Neck Pain | <input type="checkbox"/> Heart Trouble | <input type="checkbox"/> Nervousness |
| <input type="checkbox"/> Back Pain | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Sinus Trouble |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Cancer | <input type="checkbox"/> Anemia |
| <input type="checkbox"/> Neuritis | <input type="checkbox"/> Asthma | <input type="checkbox"/> Numbness/Tingling |
| <input type="checkbox"/> Other _____ | <input type="checkbox"/> Other _____ | <input type="checkbox"/> Other _____ |

If you have been injured in an accident, please complete the following questions

Date of Accident _____ Time of Accident _____ Location of Accident _____

What type of accident was it? Auto Collision On the job injury Other _____

Please describe the accident _____

Describe your injuries as best you can _____

If you were in an auto accident, please answer the following:

Were you wearing a seatbelt at the time of the accident? yes no

Were you the driver passenger pedestrian

Were you struck from behind right side front left side

Was your car moving or parked

Which car struck my car struck the other car the other car struck mine

As a result of the accident were any traffic citations issued ?

yes, to the driver of my car yes, to the driver of the other car no



Brodows Chiropractic

If you were in a workplace accident, did you report your injury to your supervisor? yes no
Did he/she recommend you seek care? yes no
Did you have post accident hospitalization? yes no

Have you missed any work? yes no dates _____

Have you been contacted by an insurance adjuster or company representative regarding this accident?

yes no

Insurance Companies involved: mine other party's (provider name _____)

Do you have an attorney that has advised you on this case? yes no

If yes: Attorney Name _____

Attorney Address _____

City _____ State ____ Zip _____

Comments: _____

Payment & Insurance

Name of person responsible for payment: _____

Does patient have health insurance? yes no

Insurance Company _____ Group Number _____

Policy Number _____

I understand and agree that I am personally responsible for paying for all services rendered to me by Brodows Chiropractic. I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore I understand that Brodows Chiropractic will prepare any necessary reports and forms to assist me in collecting from my insurance company, and that any amount authorized to be paid directly to Brodows Chiropractic will be credited to my account upon receipt. I also understand that if I suspend or terminate my care and treatment, any outstanding fees for services rendered to me will be immediately due and payable.

Patient's Signature _____ Date _____

Guardian or Spouse's Signature _____ Date _____

Payment required at time of visit