Eric A. Petermann, DC
3714 E Indian School Rd.
Phoenix, AZ 85018
602-224-00004

General Information (Please Print) Date:_____

Legal Name: _____

Address: _____ City:_____ State: ____ Zip Code: _____

Phone Cell:_____ Work:_____Date of Birth:_____ Age: _____

Marital Status: M S W D Occupation:_____

Email:_____Referred By:_____

Present Health

Describe your current problem: _____

_____

How long have you had this problem?_____

How did this happen?: _____

What is the level of pain on a scale of 0-10 (Minimal 0 to Severe 10) _____

Is this problem getting: ____ Worse ____ Better or_____Stabilized?

Past Health

Have you been treated by other doctors for this condition? _____Yes ____ No

If Yes, type of doctor and treatment:

_____

Have you ever received previous chiropractic care? _____ Yes _____ No If Yes, explain:

_____

_____

List any operations, unusual diseases, serious illness or accidents you have had (dates): _____

_____

List any drugs or medications you are currently using (prescribed and over the counter): _____

_____

Have you been treated for any health condition in the last year? ____ Yes ____ No

If Yes, describe: _____

Emergency Information

Name of Spouse/Relative: _____Cell/Business Phone: _____

List any major family medical history problems: _____

_____

Payment Information

Name or party responsible for payment:

_____

Method of payment: _____Medicare _____ Insurance _____Self Pay _____ Personal Injury _____ Other

I understand and agree that health and accident insurance policies are an arrangement between my insurance carrier and myself. This chiropractic office will prepare the necessary forms and assist me in making collections to be paid directly to this office and credited to my account upon receipt. Payment for services is due at the time of service and is ultimately the responsibility of the patient, not the insurance company. The sum we request at checkout is only an estimate of your out-of-pocket responsibility based on our understanding of your insurance benefits. I give power of attorney to endorse checks made to me, to be credited to my account. I further agree to pay for all collection costs that may be incurred to enforce collection of any amounts outstanding.

I hereby give permission of treatment:

_____ _____

Signature of patient/guardian Date