Alexander & Grenon CHIROPRACTIC CENTER, P.C.

PERSONAL HISTORY UPDATE

Dr. James D. Grenon
Dr. Daniel L. Ruddy

PATIENT IDENTITY

Today's Date: ____/____/____

Name_____ S.S.#_____-_____-_____ Birth date: ____/____/____ Sex: M / F

Address_____City_____ State_____ Zip_____

Home Phone:( )_____ Work:( )_____ Cell:( )_____ Email: _____

Marital Status: M / S / W / D / Sep. Emergency Contact: _____Phone:( )_____

Occupation: _____ Employer: _____ Work Address:_____

Spouse's Name: _____ Employer: _____ Location: _____

Family M.D. (PCP)_____ Address: _____ Phone:( )_____

Age:____ Height:_____ Weight:_____ Is there irremovable metal in your body? ☐ Y ☐ N Where?_____

PATIENT INSURANCE

1.) **Primary Insurance Company:**_____

2.) **Primary Insurance** is under: ☐ **Self** (*go to #3*) ☐ **Spouse** (*go to A-D*) ☐ **Parent** (*go to A-D*) ☐ **Other** (*go to A-D*)

A.) **Primary** Insured (Policy Holder's Name):_____

B.) **Primary** Insured Date of Birth:_____/_____/_____

C.) **Primary** Insured SS#:_____-_____-_____

D.) **Primary** Insured Place of Employment:_____

Address:_____

Phone:( )_____

3.) Do you have a **Second Insurance**? ☐ Yes ☐ No Name of Company?_____

ID #:_____ Policy Holder's Name_____

4.) Has your health insurance company or coverage **changed** over the last year? ☐ Yes ☐ No

5.) Have you seen a **Chiropractor** or **Physical Therapist** during the past year? ☐ Yes ☐ No