WELCOME TO LANGFORD CHIROPRACTIC CLINIC

3576 ROUTE 30 WEST LATROBE PA 15650-9034
(724) 539-3311

CONFIDENTIAL PATIENT INFORMATION

DATE_____ **SS#**_____ **D.O.B.**_____

NAME_____

ADDRESS_____ **HOME PHONE**_____

CITY_____ **STATE**_____ **ZIP**_____

CIRCLE:
SEX: M F MINOR SINGLE MARRIED WIDOWED DIVORCED SEPERATED

YOUR EMPLOYER_____ BUS. PHONE_____
EMPLOYER ADD._____ OCCUPATION_____
SPOUSE'S NAME_____ OCCUPATION_____
EMPLOYER ADD. _____ PHONE_____
HOW WERE YOU REFERRED TO THE OFFICE TODAY?_____
IN CASE OF EMERG. WHO SHOULD WE CONTACT?_____ PHONE_____

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PLEASE ENTER YOUR PRIMARY INSURANCE INFORMATION

PERSON RESPONSIBLE FOR ACCOUNT_____
RELATIONSHIP TO PATIENT_____ DOB_____ SS#_____
EMPLOYER_____ BUS PHONE_____
INSURANCE CO NAME_____
ADDRESS_____
SUBSCRIBER'S ID#_____ GROUP #_____

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PLEASE ENTER ANY ADDITIONAL INS. INFORMATION

INSURED'S NAME_____ INS CO NAME_____
RELATIONSHIP TO PATIENT_____ DOB_____ SS#_____
ADDRESS_____
HOME PHONE_____ EMPLOYER_____
EMP ADD._____ WORK PHONE_____
SUBSCRIBER ID#_____ GROUP # _____
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CONTINUE ON REVERSE SIDE

PATIENT NAME: _____

WHAT IS THE PURPOSE OF TODAY'S APPOINTMENT?_____

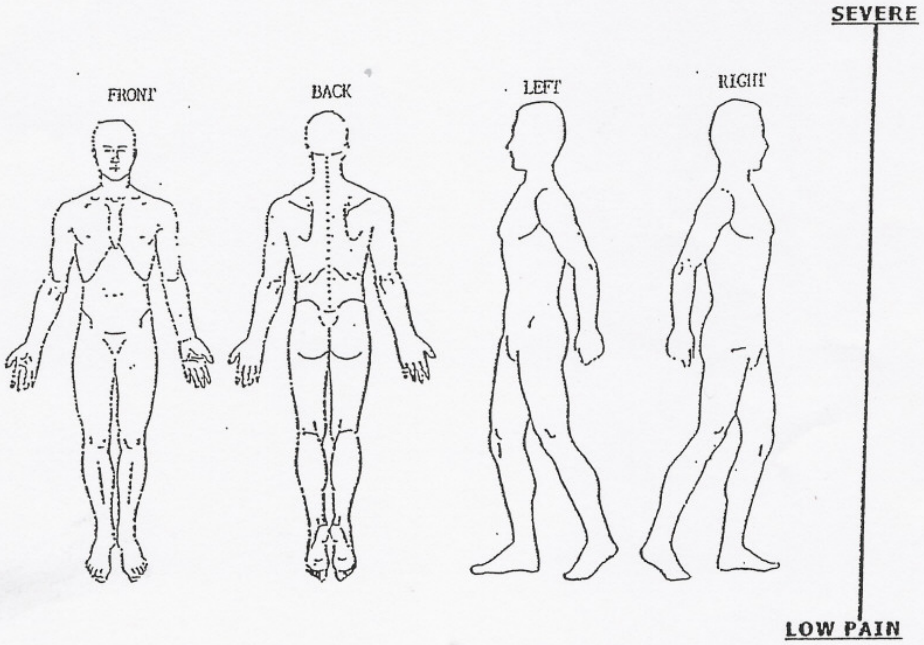
_____

DATE SYMPTOMS BEGAN(IF KNOWN)_____

WERE YOU INVOLVED IN AN ACCIDENT?_____
IF YES,_____AUTO?_____WORK?

DIRECTIONS:

1. **Please shade in, on the drawings below, the area(s) where you are experiencing pain. You may use one or all of the drawings.**
2. **Place a horizontal line across the scale indicating how much pain your are, currently, experiencing.**
3. **Sign and date the bottom of this form.**



ASSIGNMENT AND RELEASE

I, the undersigned, hereby authorize payment directly to Dr. Amel H. Langford, D.C. of all insurance benefits otherwise payable to me for services rendered. I understand that I am financially responsible for all charges, whether or not paid by my insurance, for services rendered on my behalf or my dependents behalf. I, the undersigned, authorize the above doctor and/or provider of services in this office to release information required to secure that payment of benefits. I authorize the use of this signature on all insurance submissions.

SIGNATURE OF RESPONSIBLE PARTY_____DATE_____