FULL CIRCLE HEALTH & WELLNESS

1223 US Route 202 ● Winthrop, ME 04364 ● (207) 377-9344

Patient Name: _____
Last **First** **MI**

Preferred Name: _____ **Today's Date:**_____/_____/_____

Birth Date:_____/_____/_____ **Age:** _____ **Gender:** _____

Mailing Address: _____
Street **City** **State** **Zip**

Primary Phone: _____ **Mobile Phone:** _____

Preferred Email: _____

Appointment Reminders: All patients are enrolled in automatic text message reminders. If you wish to opt out of the reminders, please select here ❑. ***Cell phone provider:*** _____

Reminder arrives: ❑ 1 hour before ❑ 2 hours before ❑1 day before

Marital Status: ❑ **Single** ❑ **Married** ❑ **Other:** _____

Employment Status ❑ **Employed** ❑ **Student** ❑ **Self-Employed** ❑ **Retired** ❑ **Other:** _____

Veteran: ❑ **Yes** ❑ **No** **First Responder/EMS:** ❑ **Yes** ❑ **No** **Teacher:** ❑ **Yes** ❑ **No**

Race

❑ Caucasian	❑ African American	❑ Hispanic	❑ American Indian/Alaskan Native
❑ Asian	❑ Asian Indian	❑ Chinese	❑ Filipino
❑ Japanese	❑ Korean	❑ Vietnamese	❑ Native Hawaiian/Pacific Islander
❑ Samoan	❑ Guamanian/Chamorro	❑ Unspecified	❑ Other: _____

Multi-racial: ❑ **Yes** ❑ **No** ❑ **Unknown**

Ethnicity: ❑ **Hispanic or Latino** ❑ **Not Hispanic or Latino** ❑ **Unspecified**

Preferred Language: _____

We invite you to discuss with us any questions regarding our services. The best health services are based on a friendly, mutual understanding between provider and patient. Our policy requires payment in full for all services rendered at the time of visit, unless other arrangements have been made with the business manager. If account is not paid within 90 days of the date of service and no financial arrangements have been made, you will be responsible for all legal fees, collection agency fees, interest charges, and other expenses incurred in collecting your balance. By signing below you agree to the following: 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 the above information and guarantee this form was completed correctly to the best of my knowledge and understand that it is my responsibility to inform this office of any changes to the information I have provided.

Signature: _____ **Date:** _____

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Chiropractic History ❑ previously seen a chiropractor ❑ First time chiropractic patient

Previous Chiropractor: _____

Type of Adjustments: _____

Condition/Date Treated: _____

Tobacco Use: ❑ Yes ❑ Former User ❑ Never Used

Type of Tobacco Used (Smoke, Chew, etc.): _____

Frequency: _____ Level of interest in quitting (Scale 0-10): _____

Current Medications and Dosages	Known Medication Allergies
❑ No Current Medications	❑ None Known
1. _____	1. _____
2. _____	2. _____
3. _____	3. _____
4. _____	4. _____

Briefly Describe You Main Health Concern: _____

_____

Are you currently diagnosed with any of the following: ❑ Diabetes ❑ Hypertension ❑ Cancer

If Yes, Please Describe: _____

Have you had an X-Ray, CT Scan, or MRI in the last 28 days? ❑ Yes ❑ No

If Yes, Which Region? _____

Emergency Contact Name: _____ Relation: _____

Home phone: _____ Work Phone: _____

Primary Care Physician: _____ Phone: _____

Employer: _____ Length of Employment: _____

Employer's Address: _____

Street City State Zip

Occupation: _____

I authorize the release of any medical or other information necessary to process my claims. I also request payment of government or prevent benefits either to myself or to the party who accepts assignment. This is a permanent authorization that I may revoke at any time by written notice. ALSO, I certify that the above information is correct. I understand that I am personally financially responsible for all services not paid for by my insurance. I am also responsible for any annual deductible applicable, co-payments, or non-covered services as may be required by my insurance plan.

Signature: _____ **Date:** _____