Wagner Chiropractic

Entrance Form

421 Cochran Road
Pittsburgh, Pennsylvania 15228
(412) 531-8701

PERSONAL INFORMATION

Patient Name: _____Social Security # _____

Address _____City _____ State ____ Zip _____

Phone # _____ Cell # _____ Email _____

Date of Birth _____ Age _____ (If under 18, Complete Guardian consent form)

Single / Divorced / Widowed/ Married ____ Spouse's Name _____

Occupation _____ Employer _____ Work Phone _____

Work Address _____City _____ Zip_____

Insurance: NO / YES **Type of INS._____**

Insurance Policy Holder: _____ (please submit Ins. Card to be copied)

Do you have a secondary insurance? No / Yes _____

Insurance Policy Holder: _____

HOW DID YOU HEAR ABOUT US?

____ Referral, Name _____

____ Health Fair, Where _____Date _____

____ Yellow Pages / ____Our sign / ____ Telemarketing / ____ Reporter

____ Insurance Directory / ____ Other _____

Have you ever been treated by a Chiropractor? No / Yes DR._____
Reason for the treatment: _____
Date of your last treatment: _____

REASON FOR TODAY'S VISIT / MAINTANCE OR HAVING COMPLAINTS

What is your reason for this appointment? _____

How long have you had this? _____ is it getting worse? ____ is it constant? _____

Have you had a similar condition in the past? ____ If so when _____

What have you done for the problem? _____

Have you ever been in a car accident? No / YES, date of accident? _____

MEDICAL HISTORY

Have you ever been diagnosed with cancer? _____Type? _____

Your Medical Doctor or PCP name _____ Phone _____

Address _____ City _____ Zip _____

Date of your last physical exam _____

Please list any other health problems or health concerns
_____
_____

List any medications you are taking
_____
_____

Have you had any surgeries?
_____
_____

Any X-Rays taken at this office will remain property of this office. I authorize Wagner Chiropractic Associates to release information to my insurance company for payment. I authorize the release of information to Wagner Chiropractic Associates from other facilities regarding treatment. The above statements are true to the best of my knowledge.

Patient Signature _____ Date _____

Parent or Guardian Signature _____ Date _____