



KEVIN DIBELLA, D.C.  
LARISSA DIBELLA, D.C.

### Confidential Patient Information

Date \_\_\_\_\_ ID # \_\_\_\_\_ Cellular Phone: \_\_\_\_\_

Name \_\_\_\_\_ Sex \_\_\_\_ Marital Status \_\_\_\_\_

D.O.B. \_\_\_\_\_ Age \_\_\_\_ Home Ph: \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

E-mail address: \_\_\_\_\_ (office purpose's only)

Social Sec # \_\_\_\_\_ Occupation \_\_\_\_\_

Company Name \_\_\_\_\_ Location \_\_\_\_\_ Work Phone #: \_\_\_\_\_

Guardian/Spouse's Full Name \_\_\_\_\_

Guardian/Spouse's DOB \_\_\_\_\_ Guardian/Spouse's Social Sec. # \_\_\_\_\_ Phone Number \_\_\_\_\_

Name of nearest relative (Not your spouse): \_\_\_\_\_ Phone \_\_\_\_\_

Is your visit due to an accident? No Yes (If yes, please fill out accident questionnaire)

#### YOUR PRESENT COMPLAINT

\_\_\_\_\_

#### BRIEFLY DESCRIBE YOUR SYMPTOMS

\_\_\_\_\_

List other doctor(s) seen for this condition

\_\_\_\_\_

Personal Medical History (if any are relevant to your medical history, please check the accompanying box.)

Muscular Dystrophy  
Rheumatic Fever

Multiple Sclerosis  
Digestive Disorders

Cancer  
Scarlet Fever

Convulsions  
Sinus Trouble

Polio  
Nervousness

Epilepsy  
Backaches



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High Blood Pressure  
Dizziness

Concussion  
Numbness

Heart Trouble  
German Measles

Hepatitis  
Arthritis

Diabetes  
Tuberculosis

Venereal Disease  
Asthma

Describe any operations you've had and the dates:

\_\_\_\_\_

Have you been treated by a physician for any health condition in the last year? Yes No

Describe Condition \_\_\_\_\_ Date of last physical exam \_\_\_\_\_

Are you now taking any medication? Yes No What kind? \_\_\_\_\_

Are you allergic to any medication? Yes No What kind? \_\_\_\_\_

Are you pregnant? Yes No Date of last menstrual period: \_\_\_\_\_

Do you have insurance? Yes No Insurance Company \_\_\_\_\_

I.D. No. \_\_\_\_\_ Policy Group No. \_\_\_\_\_

I understand and agree that chiropractic center insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that this office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to this office will be credited to my account upon receipt. I permit this office to endorse co-issued remittances for the conveyance of credit to my account. However, I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. It is my understanding that my credit may be checked if DiBella Chiropractic Center extends credit to me and I also understand that if I terminate my care and treatment, any fees for professional services rendered to me will be immediately due and payable unless prior arrangements are made. I hereby authorize the doctors at DiBella Chiropractic Center and whomever they may designate as their assistants to administer treatment as they deem necessary and I also authorize the release of any information acquired in the course of my examination or treatment. I certify that the above information is true and correct.

Patient's (Parent or Guardian's) Signature

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