
Dr. Shanna Bissonette, DC

**PATIENT CONFIDENTIAL INFORMATION:**

NAME: _____DATE:_____

Mailing Address: _____City: _____State: _____ Zip: _____

Home Phone: _____Other Phone: _____

E-mail address: _____Social Security Number: _____

Date of Birth: _____Driver's License Number: _____State:_____

Sex: M___ F___ Marital Status: _____Occupation: _____

Employer's Name: _____Address: _____

City: _____State: _____Zip: _____Phone:_____

Insurance Company: _____Policy Number: _____

In case of emergency, call: _____

Phone: _____Address: _____

Is this your first chiropractic treatment? Yes ____No ____Who referred you to this office? _____

I understand that the clinical and administrative staff may review my medical records, but all my records will be kept confidential and will not be released without my consent.

The fees for office visits are payable at the time of visit, except in certain cases where arrangements have been made with our office. As a courtesy service of In Line Chiropractic, we will provide the service of billing your insurance company directly, however, we cannot render service on the assumption that our charges will be paid by an insurance company. All professional services rendered are the direct responsibility of the patient; therefore, basic responsibility for payment is yours.

If for some reason you need to cancel your appointment, please call ahead and let us know so that we may accommodate another patient at that time. **A no show without previously arranging to reschedule or cancel will result in the full fee being charged to the patient. an office visit charge.**

_____ _____

Signature of Patient Date

_____ _____

Name of Patient's Representative (if applicable) Signature of Representative

**CASE HISTORY**

What is your major complaint? _____

_____

Other complaints? _____

How long have you had this condition? _____Have you had similar conditions in the past?
_____

What activities aggravate your condition? _____

Is your condition interfering with your: Work ☐ Sleep ☐ Daily Routine ☐ Other _____

**ACCIDENT HISTORY:**

For previously stated accidents/traumas, list Doctors for conditions:_____

_____

Length of time under care:_____ _____

Were you off work? _____If so, how long _____ Have you returned to your same job?_____

If not, why _____

**ACCIDENT INFORMATION:**

Did your accident occur while at work: Yes ☐ No ☐ Were you involved in an automobile accident? Yes ☐ No ☐ Date _____Time _____

Injury reported to employer Yes ☐ No ☐ Name of Supervisor _____

Description of accident: _____

_____

Were you injured? _____ How? _____

Location _____

Were you unconscious? _____Fractures_____ Cuts _____ Abrasions_____ Bruises_____

Patient taken to _____Hospital for _____Treatment.

Confined to hospital for _____Days _____Hours. Name of hospital doctor _____

Have you had any other personal injury or accident? Past year ☐ Past 5 years ☐ Over 5 years ☐ None ☐

Describe_____

Do you have an attorney? Yes ☐ No ☐ Name & Address_____