

**CAROLINA CHIROPRACTIC
DR. D. J. HEWETSON, D.C.**

ALL INFORMATION IS PERSONAL AND CONFIDENTIAL

PERSONAL

Date _____
Full Name: _____ Home Phone: _____
Street Address: _____
City: _____ State: _____ Zip Code: _____
Cell Phone: _____ E-Mail Address: _____
Date of Birth: _____ Age: _____ Soc. Sec. #: _____
Marital Status (Please Circle One): S M W D Number of Children: _____
Employer: _____ Occupation: _____
Employer Phone: _____
Spouse Name: _____ Employer: _____
Spouse Date of Birth: _____
Patient's Nearest Relative: _____
Emergency Phone Number: _____ Family Physician: _____

Whom May We Thank For Referring You To Us? (Please Circle One)

Friend Relative Patient Other

Name: _____ Thank You!

INSURANCE

Is this a car accident? (Please Circle One): Yes No Date of Accident: _____
Is this work related? (Please Circle One): Yes No Date of Accident: _____
Are you eligible for Medicare? (Please Circle One): Yes No

Responsible Parties Name: _____
Relationship to Patient: _____ Phone: _____
Address: _____
Auto Insurance Carrier: _____
Address: _____
Phone: _____ Policy #: _____ Claim #: _____
Name of Adjuster: _____ Phone: _____

PLEASE COMPLETE THE BACK SIDE OF THIS FORM

Major Pain Complaints:

Other Doctors Consulted:

Examinations Performed:

Medications Presently Being Taken:

Any Previous Illnesses (Major):

Any Previous Surgeries (Major or Minor):

Any Implants (Pacemaker, Arteries, IUD, Breast, Metallic Joints, Screws, Plates, Screens or Other Foreign Objects):

Do You Suspect That You Are Pregnant? (Please Circle One): Yes No

Patient Signature: _____ Date: _____

Please present any insurance information and cards to our Front Desk Receptionist when you have completed your paperwork. We will happily file all personal insurance (health and auto) for your convenience. Thank You! We appreciate your time.