"Dr. Mark" Fullerton
Chiropractic & Wellness Care
109 South Main Street
Woodruff, SC 29388

Confidential Application for Care

Today's Date _____/_____/_____ (Please Print) **E-Mail Address:**

PATIENT INFORMATION

Patient's Last Name First Middle	❑ Mr. ❑ Miss ❑ Mrs. ❑ Ms.	Marital Status (Circle) Single / Mar / Div / Sep / Wid

What do you prefer to be called?	(Former Name)	Birth Date / /	Age	# of Children	Sex ❑ M ❑ F

Street Address City State ZIP Code	Social Security	Home Phone No. ( )

P.O. Box Address City State ZIP Code

Occupation	Employer	Employer Phone No. ( )

Referred by (Please check one box) ❑ Dr. _____ ❑ Family ❑ Friend _____

❑ Internet ❑ Radio ❑ Newspaper ❑ Yellow Pages ❑ Other _____

Other Family Members Seen Here _____

INSURANCE INFORMATION (PLEASE GIVE YOUR INSURANCE CARD TO THE RECEPTIONIST)

Primary insurance ❑ BCBS ❑ State Health Plan ❑ Medicare ❑ Medicaid ❑ Other

Subscriber's Name	Subscriber's S.S. #	Birth Date / /	Group #	Policy #	Co-Payment $

Secondary Insurance (if applicable)	Subscriber's Name	Group #	Policy #

CARE REQUEST

❑ RELIEF – Symptom-oriented / short term care ❑ CORRECTIVE – Wellness-oriented / long term care

REASON FOR VISIT

Have you ever been treated by a Chiropractor before? ❑ Yes ❑ No Date of last visit / /

Please explain: _____

The reason for this visit is the result of: ❑ Work ❑ Sports ❑ Auto ❑ Chronic Please explain _____

Describe the pain and its location: _____

Condition began / / Is it getting worse? ❑ Yes ❑ No ❑ Comes and goes ❑ Constant

Is it interfering with your: ❑ Work ❑ Sleep ❑ Daily Routine If so, please explain: _____

Have you ever been treated by a Medical Physician for this condition? ❑ Yes ❑ No If so, where? _____

The above information is true to the best of my knowledge. I understand that I am responsible for payment of any services rendered to me at this office. I also authorize Dr. Mark Fullerton/Chiropractic and Wellness Care or my insurance company to release any information required to process my claims. I give my permission for my name to be used for advertising purposes. The ultimate intention of my care here is the location, analysis and correction of vertebral subluxations. I have read and understand the notice entitled PATIENT RIGHTS AT THIS OFFICE.

X _____

PATIENT/GUARDIAN SIGNATURE DATE