Plum Creek Chiropractic PA

Dr. Cynthia L. Shepard
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Confidential Patient History

Today's Date: ____________________

Name: ________________________________ Name you would like to be called: ______________________

Address: ____

Street City State Zip

Home Phone: ______________________________ Business Phone: __________________________________

Cell Phone: ______________________________ Email: ____

Date of Birth: _____/______/______ Age: ______ Gender: M F Social Security # ___________________

Current Lifestyle Status (circle one) Single Married Living w/ Partner Separated Divorced Widowed

Name of Significant Other: ________________________________

Number of Children: ______ Their Names and Ages: ____

Employer: ________________________________ Employed: full-time part-time Student: full-time part-time

Employer Address:____

Street City State Zip

Job Description: __________________________________

How did you hear about our office? ____

Reason(s) you are consulting our office: (check all that apply)

- ❑ I have a specific problem and want help with eliminating this problem.
- ❑ I am willing to participate in strategies to ensure the problem does not return.
- ❑ I want to learn about what I can do to improve my general health.
- ❑ I have no current symptoms. I am here for wellness care and to improve my overall level of health.

Payment is expected at the time of service. Exceptions include Auto Accident, and Worker's Compensation.
Please check the appropriate box:

- ❑ Cash or check
- ❑ Auto Accident

I understand and agree that health and accident insurance policies are an arrangement between my insurance carrier and me. Furthermore, I understand that the staff at Plum Creek Chiropractic PA will prepare any necessary reports and forms to assist me in making collections from the insurance company and that any amount authorized to be paid directly to Plum Creek Chiropractic PA will be credited to my account upon receipt.
I understand and agree that all services, supplements, or other items rendered me at Plum Creek Chiropractic PA are charged directly to me and that I am personally responsible for payment.
I understand and agree that if I suspend or terminate my care and treatment, any fees for professional services rendered me at Plum Creek Chiropractic PA will be immediately due and payable.

Patient Signature: ____ Date: ________________________