Dr. David B. Bridgwood

Chiropractor

417 W. Merrick Road
Valley Stream, NY, 11580
Office: (516) 561 – 4060 | Fax: (516) 561-5392
www.BridgwoodChiropractic.com

Patient Information

Name

_____

Last First

Sex:☐ M ☐F **Age_____** **D.O.B. _____**

Patient SS# _____ HT:_____ WT:_____

☐Single ☐Married ☐Widowed ☐Separated ☐Divorced

Address

_____

_____

City State Zip

Phone :_____ (Home)

_____(Cell)

Email :_____

Occupation: _____

Employer: _____

Employer Address

_____

_____

City State Zip

Employer Phone: _____ Ext:_____

Spouse Name:

_____

Last First

D.O.B:_____ SS#_____

Whom may we thank you for referring?

_____

Last First

Insurance

Who is responsible for this account? ☐Self ☐Other _____

Last First

Insurance Co._____ ID#_____ Group#_____

Is Patient Covered by additional Insurance? ☐Yes ☐ NO

If Yes, Insurance Co._____ ID#_____ Group#_____

Assignment And Release

I, the undersigned certify that I (or my dependent) have insurance covered with the above list insurance(s) and assign directly to *DR. DAVID B. BRIDGWOOD* all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits I authorize the use of this signature on all insurance submissions.

_____ _____ _____

Responsible Party Signature Relationship Date

When "I" is replaced by "We" Even "Illness becomes Wellness"

Dr. David B. Bridgwood
Chiropractor

417 W. Merrick Road
Valley Stream, NY, 11580
Office: (516) 561 – 4060 | Fax: (516) 561-5392
www.BridgwoodChiropractic.com

Accident Information

Is condition due to accident? ☐ NO ☐Yes Date:_____

Type of Accident ☐Auto ☐Work ☐Home ☐Other

To whom have you made a report of your accident? ☐Auto Insurance ☐Work ☐Worker Comp. ☐Other

Location of accident? _____
Address State ZIP

Attorney Name (If Applicable) _____ Phone#_____

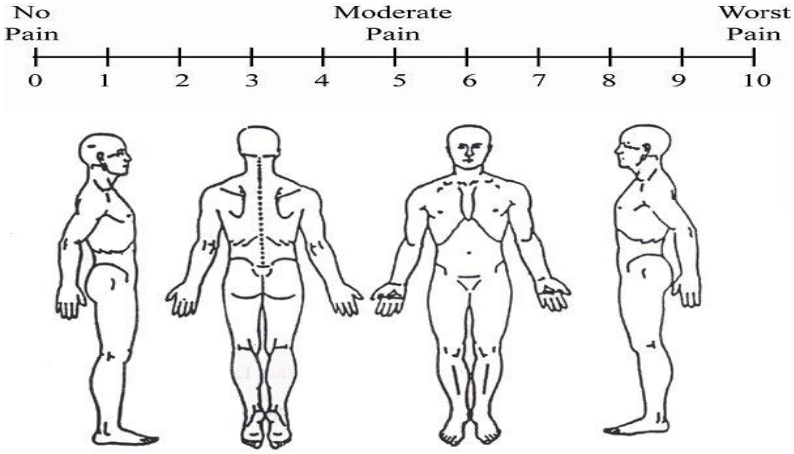
Patient Condition

Reason for visit?_____

When did your symptoms appear?_____

Is condition getting progressively worse? ☐Yes ☐No

***Mark an ☒ on the picture where you continue to have pain, numbness or tingling.**



Type of pain: ☐ Sharp ☐Dull ☐Throbbing
☐Numbness ☐Aching ☐Shooting ☐Burning
☐Tingling ☐Cramps ☐Stiffness ☐Swelling
☐Other_____

How often do you have pain?_____

Is it constant or does it come and go? ☐yes ☐NO Does your pain interfere with ☐Work ☐Sleep ☐Daily ☐Recreation

Activities or movements that are painful to perform ☐Sitting ☐Standing ☐Walking ☐Bending ☐Lying Down

History

What treatment have you received for your condition? ☐Medications ☐Surgery ☐Physical Therapy ☐Chiropractic

☐Other_____ ☐None

Name and Address of other doctor(s) who have treated for this condition _____

Date of last visit: Physical Exam _____ Spinal Exam _____ Dental X-Ray_____

Spinal X-Ray _____Chest X-Ray_____ Urine Test_____ Blood Test_____

When "I" is replaced by "We" Even "Illness becomes Wellness"

Dr. David B. Bridgwood
Chiropractor

417 W. Merrick Road
Valley Stream, NY, 11580
Office: (516) 561 – 4060 | Fax: (516) 561-5392
www.BridgwoodChiropractic.com

Place a mark on "Yes" or "No" to indicate if you have had any of the following :

Aids/HIV ☐ Yes ☐No	Emphysema ☐ Yes ☐No	Migraine ☐ Yes ☐No	Thyroid Problems ☐ Yes ☐No
Alcoholism ☐ Yes ☐No	Epilepsy ☐ Yes ☐No	Mononucleosis ☐ Yes ☐No	Tonsillitis ☐ Yes ☐No
Allergy Shots ☐ Yes ☐No	Fractures ☐ Yes ☐No	Multiple Sclerosis ☐ Yes ☐No	Tuberculosis ☐ Yes ☐No
Anemia ☐ Yes ☐No	Glaucoma ☐ Yes ☐No	Mumps ☐ Yes ☐No	Tumors, Growths ☐ Yes ☐No
Anorexia ☐ Yes ☐No	Goiter ☐ Yes ☐No	Osteoporosis ☐ Yes ☐No	Typhoid Fever ☐ Yes ☐No
Appendicitis ☐ Yes ☐No	Gonorrhea ☐ Yes ☐No	Pacemaker ☐ Yes ☐No	Ulcers ☐ Yes ☐No
Arthritis ☐ Yes ☐No	Goiter ☐ Yes ☐No	Parkinson's Disease ☐ Yes ☐No	Vaginal Infections ☐ Yes ☐No
Asthma ☐ Yes ☐No	Gout ☐ Yes ☐No	Pinched Nerve ☐ Yes ☐No	Venereal Disease ☐ Yes ☐No
Bleeding Disorders ☐ Yes ☐No	Heart Disease ☐ Yes ☐No	Pneumonia ☐ Yes ☐No	Whooping Cough ☐ Yes ☐No
Breast Lump ☐ Yes ☐No	Hepatitis ☐ Yes ☐No	Polio ☐ Yes ☐No	Other:
Bronchitis ☐ Yes ☐No	Hernia ☐ Yes ☐No	Prostate Problem ☐ Yes ☐No	
Bulimia ☐ Yes ☐No	Herniated Disk ☐ Yes ☐No	Prosthesis ☐ Yes ☐No	
Cancer ☐ Yes ☐No	Herpes ☐ Yes ☐No	Psychiatric Care ☐ Yes ☐No	
Cataracts ☐ Yes ☐No	High Blood Pressure ☐ Yes ☐No	Rheumatoid Arthritis ☐ Yes ☐No	
Chemical Dependency ☐ Yes ☐No	High Cholesterol ☐ Yes ☐No	Rheumatic Fever ☐ Yes ☐No	
Chicken Pox ☐ Yes ☐No	Kidney Disease ☐ Yes ☐No	Scarlet Fever ☐ Yes ☐No	
Diabetes ☐ Yes ☐No	Liver Disease ☐ Yes ☐No	Stroke ☐ Yes ☐No	
☐ Yes ☐No	Measles ☐ Yes ☐No	Suicide Attempt ☐ Yes ☐No	

EXERCISE	WORK ACTIVITY	HABITS	
☐ None	☐Sitting	☐Smoking	Packs/Day _____
☐Moderate	☐Standing	☐Alcohol	Drinks/Week_____
☐Daily	☐Light Labor	☐Coffee/Caffeine Drinks	Cups/Day_____
☐Heavy	☐Heavy Labor	☐High Stress Level	Reason _____

Are You Pregnant? ☐ Yes ☐No **Due Date**_____

Injuries/Surgeries (List all Falls, Head Injuries, Broken Bones, Dislocations, Surgeries, etc.…)

MEDICATIONS	ALLERGIES	VITAMINS/HERBS/MINERALS

When "I" is replaced by "We" Even "Illness becomes Wellness"