DR. SERGE LAZATIN, D.C. / ADVANCED CHIROPRACTIC WELLNESS + SPORTS
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PATIENT INFO SHEET

Patient Name: _____ Birthday: _____ Sex: M/F

Address: _____ City: _____ State: _____ Zip: _____

Telephone: _____ Email: _____ Social Security #: xxx-xx-_____

Occupation: _____ Employer: _____

Insurance Name: _____ Insurance Phone Number: _____

Subscriber Name: _____ Subscriber Birthday: _____

Subscriber ID#: _____ Group #: _____

Describe your current problem and how it began: _____

_____

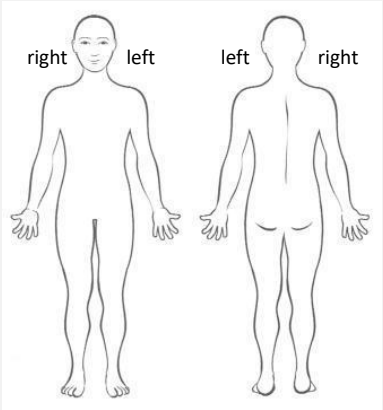
Date of injury: _____ Were you injured at work? (circle): Yes No Car Accident?: Yes No

Have you had the following taken? (circle): X-Ray MRI CT Date & Body Part Taken: _____

What type of treatment had been done for the injury (PT, Medication, Surgery, etc): _____

Who referred you to the office (insurance, yelp, etc): _____

Please mark area of pain & rate from 0-10



0 1 2 3 4 5 6 7 8 9 10
No pain **max pain**

Check all that applies to you:

__History of recent infection
__Recent fever
__HIV/AIDS
__Diabetes
__Pacemaker
__Metal implants
__High blood pressure
__Cancer/tumor
__Osteoporosis
__Pregnancy
__Visual Disturbance
__Dizziness
__Arthritis
__Tobacco use
Surgeries: _____
Current Medications: _____
_____

I certify the above information is complete and accurate. If the health plan information is inaccurate, or if I am not eligible to receive health care benefit through this provider, I understand that I am liable for all charges for services rendered and I agree to notify this doctor immediately whenever I have changes in my health condition or health plan coverage in the future.

Patient Signature: _____ **Date:** _____