Patient Confidential History Form

The following information is needed for our files so we may better serve you as our patient. Please fill in all portions of the form and bring to your next visit. We do not share your demographical information with anyone. If you need help please ask the doctor, phone the hotline at 920-710-1711, or email dr.tjrinaldi@gmail.com

Name____

Address____City_______________________Zip____________

Best phone number to reach you ___________________________ Birth Date__________________________________
Email (if you wish to receive informative helps to better care for yourself and your family)

____ @ ____

When was your last chiropractic adjustment? _____________________ By whom? _____________________________
Please list any health issues you've had over the last 6 months:

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List any past surgeries____ Date ______________________

____ Date ______________________

____ Date ______________________

List any prescribed medications you are taking ____

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***Office Policy**: Services must be paid for at time of service, unless prior arrangements have been made with the doctor. Chiropractic wellness adjustment: $25.

I understand that Dr. TJ Rinaldi is responsible for subluxation (mis-alignment) identification and reduction only. I understand that Milwaukee Chiropractic Group LLC is responsible for wellness adjustments and that wellness / maintenance care will not be submitted to insurance carriers. Should I request an itemized statement, one will be provided to me for third party reimbursement as I see fit. This may include, but not be limited to insurance carriers, heath savings plans, health savings accounts, or FLEX expenditure accounts.

Signature:____

Today's date _____________________________________