

DFW HOLISTIC HEALTH

9149 Belshire Drive, Suite 100, North Richland Hills, TX 76182

CONFIDENTIAL PATIENT INFORMATION FORM

PLEASE PRINT legibly and fill out ALL information

Today's Date _____ Referred by _____
Last Name _____ First Name _____
Address _____ City _____
Phone _____ State, Zip _____
Age _____ Email _____
Birthday _____ Male / Female (circle one) SS# _____
Circle one: Single Divorced Widowed Married Spouse _____
Occupation _____
Employer _____ Work Phone _____

Person responsible for account (if other than patient) _____
Relationship to patient _____ SS# _____
Address _____ City _____
Phone _____ State, Zip _____

Emergency Contact _____ Relation to patient _____
Address _____ City _____
Phone _____ State, Zip _____

What is your major complaint? _____
How long have you had this? _____
Have you had this or similar conditions before? _____ When? _____
What is the status of your condition? (circle one) Constant Comes & goes Getting progressively worse
What aggravates your condition? _____
What improves your condition? _____
My condition interferes with (circle all that apply) Work Sleep Daily Routine Other _____
What previous diagnoses and/or treatments have you received for this condition? _____

Any additional complaints? _____
What are you willing to do to resolve your problem(s)? _____
What are you NOT willing to do or change? _____

DFW HOLISTIC HEALTH

Patient Name _____

D.O.B. _____

I hereby give my consent to **Dr. Michael Phillips, DC, CCN, and/or Dr. Charlanne Gasper, DC, CCN**, to provide chiropractic and/or nutritional services to myself and/or my family. I understand that there is a fee for services and products, and that **fees are payable at the time services are rendered or products are purchased**. I hereby agree to such fees, and understand that I am liable for all legal fees, if collection services become necessary.

Patient / Responsible Party _____

Date _____

I hereby give my consent to receive massage therapy services from a **licensed and independently contracted massage therapist** at DFW Holistic Health. I understand that there is a fee for services, and that **fees are payable at the time services are rendered**. I hereby agree to such fees and understand that I am liable for all legal fees, if collection services become necessary.

Patient / Responsible Party _____

Date _____

If you are unable to keep a scheduled appointment, please provide at least a 24-hour notice.

If there is less than 24 hours notice, a missed appointment fee of \$25 will be charged.

The \$25 fee is for each appointment missed.

For example, if a missed appointment is with one of the doctors AND the massage therapist, the charge would be \$50.

You can cancel your appointment via:

Office phone (817) 801-5111 (call or text)

Email: dfwholistichealth@gmail.com

Patient / Responsible Party _____

Date _____
