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 different than patient) ____________

Relationship to patient ____________ SS# ____________

Address ____________

Emergency Contact ____________ Relationship ____________

Address ____________

Phone ____________ Email ____________

What is your major complaint? ____________

How long have you had this? ____________

Have you had this or similar conditions before? ____________ When? ____________

Status of your condition? (circle one) Constant Comes & goes Getting progressively worse

What aggravates your condition? ____________

What improves your condition? ____________

It interferes with (circle all that apply Work Sleep Daily Routine Other ____________

List previous diagnosis and/or treatments you have received for this condition. ____________

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Any additional complaints? ____________

What are you willing to do to resolve your problem(s)? ____________

What are you not willing to change or do? ____________

DFW Holistic Health

Patient Name ______________________________ **Date** ____________________

I hereby give my consent to **Dr. Michael W. 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 any and all legal fees if collection services become necessary.

Patient/Responsible Party ______________________________ Date ____________________

I hereby give my consent to **Kristi Meck, LMT**, to provide therapeutic massage services to myself and /or my family. I understand that there is a fee for services and/or products, and that f***ees are payable at the time services are rendered*** . I hereby agree to such fees, and understand that I am liable for any and all legal fees if collection services become necessary.

Patient/Responsible Party ______________________________ Date ____________________

If you are unable to keep a scheduled appointment, please provide 24 hours notice.

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

The $25 fee is for each appointment missed. (For example, if a missed appointment is with the massage therapist AND one of the doctors, the charge would be $50.)

You can cancel your appointment via any of these contacts:
Office Phone: 817-801-5111 Office Text: 817-821-1913 Email: dfwholistichealth@gmail.com

Patient/Responsible Party ______________________________ Date ____________________