Dr. Steve Troyanovich
322 Susan Drive, Suite B ▪ Normal, Illinois 61761
Telephone 309.454.5556 ▪ Facsimile 309.454.5669 ▪ Email: drstevetroyanovich@hotmail.com

ADVANCED
CHIROPRACTIC CLINIC

CONFIDENTIAL PATIENT INFORMATION

Date: _____ Full Name: _____ Phone: _____

Address: _____
Street City State Zip

SS#: _____ Age: _____ Date of Birth: _____ Marital Status: M S W D

Height: _____ Weight: _____ Pregnant? Yes No Unsure No. of Children: _____

Occupation: _____ Employer: _____ Employer Phone: _____

Name of spouse or guardian: _____ Email Address: _____

Who may we thank for referring you to us? _____

Reason for appointment & related health problems:	Date started or for how long?	Have you had this before?	Injury related?
1. _____	_____	Yes / No	Yes / No
2. _____	_____	Yes / No	Yes / No

Medical Doctors or Chiropractors you have seen in the past year:

Name: _____ Condition: _____

Name: _____ Condition: _____

Previous surgeries (please list all types):

1. Type: _____ Date: _____
2. Type: _____ Date: _____
3. Type: _____ Date: _____

Previous accidents or injuries (especially those that relate to your present problems):

1. Type: _____ Date: _____
2. Type: _____ Date: _____
3. Type: _____ Date: _____

INSURANCE INFORMATION

Patient's Name: _____ Phone #:

Insured's Name: _____ Phone #:

Insured's Address: _____
Street City State Zip

Insured's ID# or SS#: _____

Insured's Group Name or #: _____

Name of Insurance Company: _____

Insurance Company's Address: _____
Street Suite # or P.O. Box #

_____
City State Zip

Insurance Company's Phone #: _____

Current Medications (including any vitamins or herbal supplements):

_____

_____

Please circle the following conditions you may have had or have now:

Allergy	Alcoholism	Anemia	Arthritis
Back aches	Constipation	Convulsions	Cold Sores
Cancer	Diabetes	Sinus	Venereal Disease
Eczema	Gall Bladder	Heart Attack	High Blood Pressure
Stroke	Epilepsy	Measles	Blood Vessel Disease
Headaches	Heart Disease	Ulcers	Multiple Sclerosis
Neck Pain	Back Pain	Polio	Menstrual Cramps
Mumps	Diarrhea	Whooping Cough	Irregular Periods
Neuritis	Nervousness	Depression	Thyroid Problems
Gout	Pneumonia	Pleurisy	Low Blood Sugar
Malaria	Tuberculosis	Migraine	Miscarriage

Other: _____

ASSIGNMENT & RELEASE

I authorize release of information to family physicians and employer.
I authorize release of information to insurance companies.
I authorize the taking of photographs and x-rays to be used for treatment purposes.
I authorize the performance of other diagnostic and therapeutic procedures for treatment purposes.
I authorize my insurance benefits to be paid directly to: **Dr. Steve Troyanovich**
322 Susan Drive, Suite B
Normal, IL 61761

Patient's Signature: _____ Date: _____

PAYMENT POLICIES

1. PAYMENT FOR YOUR FIRST DAY'S SERVICES IS DUE AT THE COMPLETION OF YOUR OFFICE VISIT.

2. At the completion of your office visit, you will be advised as to a time you can return for your second consultation when the doctor will inform you as to your examination results and whether or not your case has been accepted. You will then also be advised concerning financial arrangements and insurance coverage as appropriate.

I acknowledge that I am financially responsible for non-covered services. I also understand that if I terminate my care and treatment, any fees for professional services rendered me will be immediately due and payable.

Patient's Signature: _____ Date: _____

Guardian's Signature: _____ Date: _____