



1915-A Westfield Ave., Scotch Plains, NJ 07076 (908) 490-1667

PATIENT INFORMATION (Please print clearly and answer all questions on reverse side of this form)

_____ (____) _____ - _____
 Last Name First Name MI Phone

 Address City State Zip

E-Mail Address: _____ How were you referred to Dr. Trainor? _____

Please Note: From time to time, we may need to contact you regarding missed appointments or other issues. This may involve leaving a message for you if there is an answering machine or voice mail available.

Birth Date	Age	Sex	Marital Status	Social Security #
____/____/____ Month Day Year	_____	<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> Other	____-____-____

EMPLOYMENT INFORMATION

 Employer Your Position (____) _____ - _____
 Office Phone

 Address City State Zip

INSURANCE INFORMATION

 Responsible Party (Subscriber Name) Relationship to Patient (Self, Spouse, Child, Other) ____/____/____
 Date of Birth

 Address (if different from above address) City State Zip

Group Insurance
 Medicare
 Additional or supplemental insurance: _____
 Workman's Compensation
 Auto Injury
 Personal Insurance
 Medicaid

 Insurance Company Plan Type (HMO, PPO) Patient ID# and Group #

ASSIGNMENT AND RELEASE

I plan to pay by: Cash Check Credit Card (MasterCard, Visa or Discover)

I certify that the above information is true and correct. I, the undersigned, certify that I (or my dependent) have insurance coverage as shown above (or by copy of insurance card) and assign directly to Dr. Trainor all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize Dr. Trainor to release any information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Signature _____ Date _____

(Please turn over and complete other side)



Patient Information	
Main Complaint and Symptoms: _____ _____	List any previous accidents or injuries: _____ _____
When did you first notice this problem? _____	List any major illnesses: _____ _____
How does this condition interfere with normal living or working? _____	List any operations: _____ _____
Was your condition caused by: <input type="checkbox"/> Auto <input type="checkbox"/> On the job <input type="checkbox"/> Other Describe Accident: _____	Are you currently under any doctor's care? <input type="checkbox"/> Yes <input type="checkbox"/> No (If yes, who and why?) _____ _____
Have you had any previous treatment for this or similar conditions? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, when? _____ How long were you treated? _____ Who treated you? _____ Results? _____	Are you currently taking any medication? <input type="checkbox"/> Yes <input type="checkbox"/> No (List names of medication/what they are treating) _____ _____ _____ _____
Have you been under previous chiropractic care? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, who treated you? _____	Is there any possibility that you may be pregnant? <input type="checkbox"/> Yes <input type="checkbox"/> No First day of your last menstrual period: Date and month: _____



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DOCTOR'S NOTES

(Please turn over and complete other side)