Welcome

Dr. Joel J. Angyal,D.C.,D.A.A.P.M
510 Anderson Avenue
Cliffside Park, NJ 07010

Patient Information:

Name: _____ Birthdate: _____/_____/_____ Age: _____ ☐ Male ☐Female

Address: _____ City: _____ St._____ Zip: _____

Home# ( ) _____ Cell# ( ) _____ Work# ( ) _____

Social Security#: _____ Driver's License #: _____

Occupation: _____ Employer: _____

Address _____ City _____ State _____ Zip _____

Marital Status: ☐Single ☐Married ☐Divorced ☐Widowed EMAIL: _____

How Did you hear about our office: ☐Ins. Co. ☐Google ☐Gothem Diner ☐Advertising ☐Attorney

□ Other – Name of referral: _____

In Case of Emergency

Contact Name _____

Relationship _____

Phone # _____

Are you Pregnant? ☐Yes ☐NO

What is your Height? _____ What is your weight?_____

Are you taking any of the following medication?

☐Pain killers ☐muscle ☐relaxers ☐tranquilizers
☐Stimulants ☐blood thinner ☐nerve pills

Who is your Primary Physician? _____ Phone # ( ) _____

Have you ever been treated by a Chiropractor before? ☐Yes ☐No

Did You See another doctor for this condition? ☐Yes ☐No if so, who _____

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Health History

Have you been tested positive for Covid? ☐ Yes ☐No If so, did you have the antibodies test? ☐ Yes ☐No

List All Medications you are currently taking: _____

_____

_____

List any medical conditions or surgeries you have had: _____

_____

List any past accidents with dates (car accidents, slip & falls, sports) _____

_____

Have you had any of the following diseases/medical conditions?

Y / N – Heart Attach/Stroke	Y / N – Heart Surgery/Pacemaker	Y / N – Heart Murmur
Y / N – Congenital Heart defect	Y / N – Mitral Valve Prolapse	Y / N – Rheumatic Fever
Y / N – Sinus Problems	Y / N – Thyroid	Y / N – Hepatitis
Y / N – HIV / Aids	Y / N – Diabetes/Tuberculosis	Y / N – Cancer
Y / N – Asthma	Y / N – Fainting/Seizures/Epilepsy	Y / N – Anemia
Y / N – Psychiatric Problems	Y / N – Shingles	Y / N – Kidney Problems
Y / N – Arthritis	Y / N – Difficulty Breathing	Y / N – Artificial Bones/Joints
Y / N – High Blood Pressure	Y / N – Hernia	Y / N – Gastro Problems

List any family History:

_____

_____

To the best of my knowledge, the questions on this form have been answered accurately. I understand that providing incorrect info can be dangerous to my health. It is my responsibility to inform the doctor's office of any changes in my medical status.

I also give permission to Dr. Angyal's office to submit my medical information to the insurance company upon their request. ☐ Yes ☐No

_____ _____

Patient Signature Date