Patient Information

Acct # ________

<u>Please complete each question.   If the question does not apply please use N/A.</u>

<u>Please Print</u>

Today's Date ____ /____ / ______

Full Legal Name ____ Age ________ DOB ____ / ____ / ______

First **Middle** **Last**

Home Address ____________________________ City ______________State _____ Zip Code ___________

Home Phone (   ) ______________________ Cell Phone (   ) ____________________________

E-Mail Address _________________________________ Social Security # _________________________

Marital Status   S   M   D   W   Name of Spouse ____

Names and Ages of Children ____

____

Occupation _________________________________ Employer ________________________________

Business Address _____________________________ City ________________ State ____ Zip _________

Business Phone (   ) _______________________   May we contact you at work?   Yes   No

Nearest relative not living with you _______________________ Ph # (   ) ______________ Relationship ________________

How were you or who referred you to our clinic? ____

What are your main concerns to see the doctor today? ____

____

Have you ever received Chiropractic care?   Yes   No   Chiropractor's name __________________________

Date of last adjustment ______ / ______ / _______   Reason for ending care __________________________

Name of current medical doctor __________________________ Phone (   ) _________________________

Date of last medical examination _____ / _____ / ________

<u>Which of the Following Most Clearly Describes Your Current Goals For Health</u>

_______ I am only concerned with pain relief.

_______ I am concerned with pain relief and learning how to improve my health to prevent future health concerns.
(May include fitness, dietary, sleeping and positive affirmation habit modification)

Acct # ________

Have you had any of the following accidents in your past history? (Circle all that apply)

Automobile Motorcycle Bicycle Sports Slips/Falls

Other ____

Have you had exposure to any of the following stressors? (Circle all that apply)

Drugs/Chemicals Smoke Alcohol Caffeine Emotional Stress

Other ____

FINANCIAL INFORMATION

Payment in full is required on each visit unless prior arrangements have been made in advance.

Please indicate your preferred method of payment. ___ Cash ___ Check ___Credit Card

If you have insurance, please indicate the type of policy and name of insurance carrier:

___ Medical Insurance ___ Auto Accident Med Pay ___ Medicare ___ Medicaid ___ Worker's Comp

Name of Insurance Carrier: ___________________________________ Policy # _________________________

Please present your insurance card to the reception desk on your initial visit and any time your insurance carrier changes.

FINANCIAL AGREEMENT: I authorize the treating Chiropractor to furnish information concerning my condition and direct any applicable insurer to pay directly to the doctor or clinic any and all benefits due as a result of evaluation and treatment. I am aware that I am personally responsibility for charges and any balance not covered by insurance. I agree to pay any unpaid balance, reasonable attorney fees, costs and expenses, collection and litigation fees, if necessary, to collect any over due balance. I hereby state and agree that a photocopy of this document will be valid and binding on all parties involved as the original copy.

INFORMATION CONSENT TO RECEIVE CHIROPRACTIC CARE: I, the undersigned, give the doctor permission and authority to provide care in accordance with standard chiropractic tests, analysis, diagnosis and treatment. Chiropractic care seldom causes any complications, but in rare cases, due to underlying physical defects, deformities or pathologies may render a patient susceptible to injury. The doctor will not provide care if they are aware of any contraindication that may be present. It is the responsibility of the patient to make it known to the doctor or health care provider if they are aware of any underlying deformities or defects that may not otherwise come to the attention of the doctor.

If you are under the age of 18 please list the name of your Parent or Guardian ____

__________________________________ Date____ / ____ / ____ __________________________________ Date ___ / ____ / ____

Signature of Patient Signature of Parent or Guardian

Thank you for choosing our doctors.
We look forward to helping you develop optimum health, vitality and wellness!

10/09