Patient Information

Last Name: _____ First Name: _____ Middle Initial: _____

Birthdate: _____ Sex: (circle) M or F Marital Status: (circle) Single Married Widowed Divorced

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Emergency Contact & Phone Number: _____

Email Address _____

Employer: _____Occupation:_____

Referred By: _____ Todays Date_____

Insurance Information

Name of responsible party (if other than above) _____

Name of Insurance Company: _____

Name of Insured Individual: _____ Birthdate: _____

Relationship to Insured Individual: _____ Phone Number: _____

Billing Address: _____

Is your visit a result of a work injury? _____ Auto accident/injury? _____

*Please give your insurance card and driver's license to the receptionist when you arrive for your appointment.

Health History **(Please check any symptoms that apply to you)**

_____Headache	_____Upper Back Pain	_____Numbness Hands/Fingers	Left	Right
_____Neck Pain	_____Mid Back Pain	_____Pain Shoulders/Arms	Left	Right
_____Neck Stiffness	_____Chest Pain	_____Pain in Legs	Left	Right
_____Double Vision	_____Short of Breath	_____Numbness in Legs	Left	Right
_____Dizziness	_____Low Back Pain	_____Numbness in Feet/Toes	Left	Right
_____Anxiety	_____Fatigue	_____Difficulty Walking		
_____Swelling	_____Tension	_____Difficulty standing		
_____Irritability	_____Fainting	_____Difficulty Bending		
_____Nausea	_____Cold Hands	_____Difficulty Rising and Sitting		
_____Tremors	_____Cold Feet	_____Difficulty Lifting Objects		
_____Depression	_____Cramping	_____Difficulty Driving		

Please list any medications you are currently taking: _____

_____

Please list previous surgeries: _____

_____

Have you ever been treated by a chiropractor? If yes, please explain why: _____

_____

Is there any chance you may be pregnant? YES NO

Reason for visit today

Please describe the symptoms of your current condition: _____

_____

_____

_____

When did this condition begin? _____ is condition getting worse? _____

Have you had this or similar conditions in the past? If yes, please explain: _____

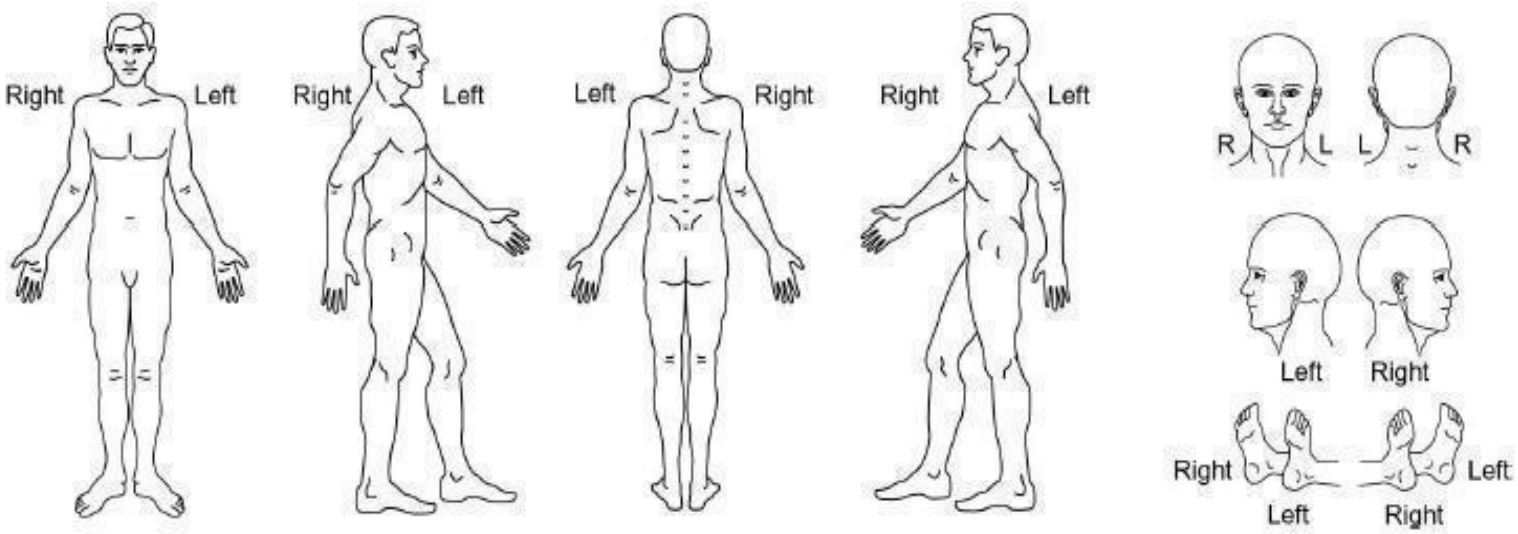
_____

Have you ever been treated for this condition in the past? If yes, who treated you? _____

On a scale of 1 -10 (1 = discomfort) (10 = extreme pain) please indicate how you feel today: _____

Please mark area(s) of injury or pain on the body diagram below using the appropriate symbols.

Numbness (-------) **Pins & Needles (+++++)** **Aching (XXXXX)** **Burning (^^^^^)** **Stabbing (. . . . .)**



Financial Responsibility

Our policy requires payment for all services rendered at the time of visit, unless other arrangements have been made with the business manager. Patient, hereby, agrees to be financially responsible for all charges incurred at the office including insurance deductibles, copays, co-insurance, and all rejected or non-covered services by the insurance company. It is your responsibility to know your chiropractic insurance coverage before being treated in our office as we do not pre-check insurance coverage.

We accept Visa, Master Card, Discover, Checks, and Cash for payment.

Accounts which are more than 90 days past due will be submitted to our collection agency for non-payment and a 30% additional fee on the balance will be added to your total balance.

If you do not cancel your appointment 24 hours prior to arrival we reserve the right to charge a $50.00 no-show charge to your account.

Signature: _____Date:_____

Release of Information

Patient, hereby, authorizes this office to release any information pertinent to his/her case to any insurance company; adjuster and attorney involved in this case; and, hereby, release this clinic of any consequence thereof.

Signature: _____ Date: _____

Assignment of Insurance Payments

Patient, hereby, instructs and directs insurance company to pay by check or electronic deposit to be made directly to this office the professional or medical expense benefits allowable, for billed services. A photocopy of this assignment shall be considered as effective and valid as the original. It is your responsibility to contact your insurance carrier regarding you chiropractic coverage.

Signature: _____ Date: _____