Welcome

ABOUT YOU

NAME: ____ DATE: ___________________________

WHAT DO YOU PREFER TO BE CALLED?____

SOCIAL SECURITY #: ____________________ MALE ( ) FEMALE ( )

BIRTHDATE: ______________________________ AGE: ___________________

HOME ADDRESS: ____

CITY: ___________________________ STATE: ______________________ ZIP: ___________________

HOME PHONE: ( ) ______________ WORK: ( ) ______________ CELL: ( ) ________________

EMPLOYER:______________________________OCCUPATION:________________________________

ADDRESS: ____

CITY: ___________________________ STATE: ______________________ ZIP: ___________________

SINGLE ( ) MARRIED ( ) DIVORCED ( ) WIDOWED ( )

NAME OF SPOUSE: ____________________________________ # OF CHILDREN: _________________

NAME AND PHONE # OF PERSON TO CONTACT IN CASE OF AN EMERGENCY:

____

HOW WERE YOU REFERRED TO THIS OFFICE:
( ) PERSON, LIST NAME SO WE MAY THANK: ____

( ) DOCTOR ( ) INSURANCE DIRECTORY ( ) YELLOW PAGES ( ) OTHER:________________

INSURANCE INFO

WHO IS RESPONSIBLE FOR YOUR BILL? ( ) SELF PAY ( ) HEALTH INSURANCE

( ) WORKER'S COMPENSATION ( ) PERSONAL INJURY ( ) OTHER

PRIMARY INSURANCE COMPANY NAME: ____

INSURED'S NAME:____________________________INSURED'S DOB:__________________________

INSURED'S SS#_____________________RELATIONSHIP TO THE INSURED:_______________________

INSURED EMPLOYER:____________________EMPLOYER PHONE #:____________________________

SECONDARY INS COMPANY NAME: ____

INSURED'S NAME:____________________________INSURED'S DOB:___________________________

INSURED'S SS#:____________________RELATIONSHIP TO THE INSURED:_________________________

INSURED'S EMPLOYER:___________________EMPLOYER PHONE #: ___________________________

IF THIS IS A WORKER'S COMPENSATION CLAIM, PLEASE FILL OUT THIS SECTION:

DATE OF INJURY: _______________ WAS INJURY REPORTED TO EMPLOYER? ______________________

INSURANCE INFO CONTINUED

HAVE YOU FILLED OUT INITIAL PAPERWORK? ____

HAVE YOU SEEN ANY OTHER DOCTORS FOR THIS CONDITION? _________________________________

HAVE YOU FILED ANY OTHER WORKER'S COMP CLAIMS IN YOUR LIFETIME? ___________________

DO YOU HAVE AN ATTORNEY? IF SO, WHOM? ______________________ATTY PHONE #:____________

IF THIS IS AN AUTO ACCIDENT/PERSONAL INJURY, PLEASE FILL OUT THIS SECTION:

DATE OF INJURY: ___________________ WHO WAS AT FAULT? ___________________________________

DO YOU HAVE AN ATTORNEY? IF SO, WHOM? ______________________ATTY PHONE #:____________

INFORMATION OF YOUR CAR INSURANCE: ____

INFORMATION OF OTHER PARTY'S INSURANCE: ____

HAVE YOU SEEN ANY OTHER DOCTORS/HOSPITAL FOR THIS CONDITION? _______________________

HAVE YOU HAD ANY OTHER SERIOUS CAR ACCIDENTS? ____

PRESENT COMPLAINT

PRESENT COMPLAINT: ____

____

HOW DID IT START? ____

WHAT DATE DID IT START? ____

WHAT MAKES IT BETTER? ____

WHAT MAKES IT WORSE? ____

HAVE YOU EVER HAD THIS OR SIMILAR CONDITIONS BEFORE? ________________________________

HAVE YOU SEEN ANY OTHER DOCTORS FOR THIS CONDITION ? ________________________________

IS THIS CONDITION ( ) CONSTANT ( ) COMES AND GOES ( ) SHARP PAIN ( ) DULL PAIN

( ) NUMBNESS OF ARM OR LEG INVOVLED

IS THIS CONDITION INTERFERING WITH ( ) WORK ( ) SLEEP ( ) DAILY ROUTINE

IS THIS CONDITION GETTING ( ) BETTER ( ) WORSE ( ) SAME

HEALTH HISTORY

LIST ALL MEDICATIONS YOU ARE TAKING: ____

____

LIST ALL SURGERIES (WITH DATES) THAT YOU HAVE HAD: ______________________________

____

LIST ANY OTHER MEDICAL PROBLEMS THAT YOU HAVE HAD: ______________________________

____

HEALTH HISTORY CONTINUED

LIST ANY SERIOUS ACCIDENTS THAT YOU HAVE HAD: ___________________________________

____

LIST ALL ALLERGIES: ____

LIST ANY EMOTIONAL OR MENTAL DISORDERS: _______________________________________

DO YOU SMOKE? ________________________ HOW MANY PACKS A DAY? ________________

HAVE YOU EVER SEEN A CHIROPRACTOR BEFORE? WHEN? ______________________________

WHO IS YOUR MEDICAL DOCTOR? (OPTIONAL) _______________________________________

HEALTH CONDITIONS OF YOUR IMMEDIATE FAMILY: ___________________________________

____

ARE YOU PREGNANT? HOW MANY WEEKS? ____

DO YOU HAVE ANY METAL IMPLANTS OR A PACEMAKER? _____________________________

- We invite you to discuss with us any questions regarding our services. The best health services are based on a friendly, mutual understanding between provider and patient.
- Our policy requires payment in full for all services rendered at the time of visit, unless other arrangements have been made with the business manager. If account is not paid within 90 days of the date of service and no financial arrangements have been made, you will be responsible for legal fees, collection agency fees, and any other expenses incurred in collecting your payment.
- I authorize the staff to perform any necessary services needed during diagnosis and treatment. I also authorize the provider to release any information required to process insurance claims.
- I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes in my medical status.

SIGNATURE ____ DATE _______/_______/_______