PATIENT INFORMATION FORM

First Name_____ Middle Initial_____

Last Name_____

Spouse's Name_____

Address_____

City, State, Zip_____

Home Phone_____ Work Phone_____

Cell Phone_____ Fax_____

E-Mail Address:_____

Age_____ Sex: ❑ Male ❑ Female

Birth Date:_____ SS No._____

Children's Names and Ages:_____

_____

Occupation:_____

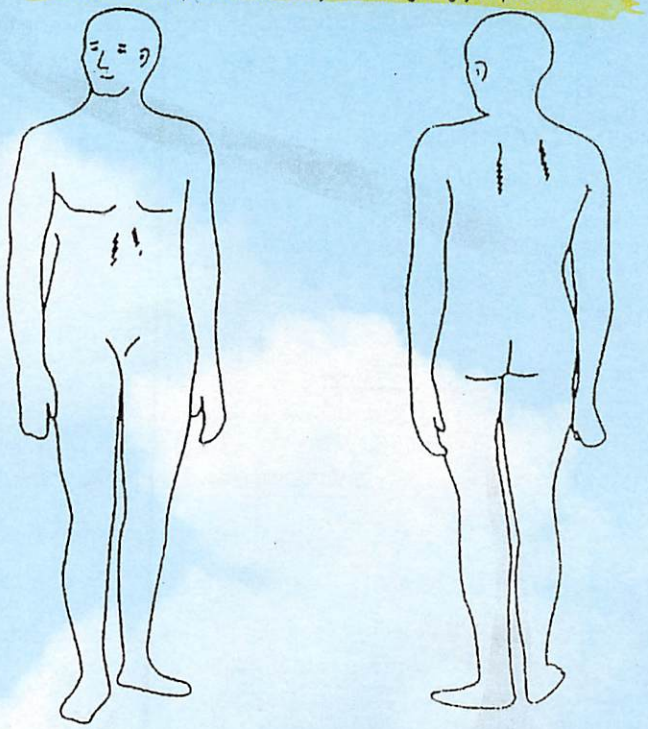
Employer_____

Address_____

City, State, Zip_____

Referred by:_____

Please mark the parts of the body that are giving you problems.



Person Responsible For Account_____

Method of Payment: ❑ Cash ❑ Check ❑ Credit Card ❑ Insurance

Name of Health Insurance Co._____

List your chief complaints in order of severity:

1._____ For How Long?_____

2._____ For How Long?_____

3._____ For How Long?_____

Is this condition due to an: ❑ Auto Accident ❑ Work Injury ❑ Other Accident ❑ Unknown Cause ❑ Illness

Are the symptoms: ❑ Improving ❑ Getting Worse ❑ About the Same ❑ Come and Go Date symptoms appeared_____

Check which activities aggravate your condition: ❑ Standing ❑ Walking ❑ Sitting ❑ Lying ❑ Bending ❑ Lifting ❑ Twisting ❑ Coughing

Have you had these symptoms before ❑ Yes ❑ No If so, when?_____

Have you seen a doctor for this condition? ❑ Yes ❑ No ❑ M.D. ❑ Chiropractor ❑ Osteopath ❑ Acupuncturist ❑ Dentist ❑ Podiatrist

Dr. Name_____ Date Consulted_____ Diagnosis_____

Are you currently under medication? ❑ Yes ❑ No If so, what kind?_____

Father, Mother, Brother, Sister, Children with similar problems? ❑ Yes ❑ No If so, who?_____

Have you every been diagnosed with cancer? ❑ Yes ❑ No If so, what kind?_____

Are you presently taking birth control pills? ❑ Yes ❑ No

Are you involved in an exercise program? ❑ Yes ❑ No If yes, explain:_____

Favorite Hobbies or Interests:_____

Confidential: Please make the doctor aware if you are HIV positive, or if you have any other communicable diseases, i.e., TB, Hepatitis.

FAMILY CHIROPRACTIC CENTER

9630 Ravenna Road

Suite 100

Twinsburg, OH 44087

TERMS OF ACCEPTANCE

When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for both to be working towards the same objective.

Chiropractic has only one goal. It is important that each patient understand both the objective and the method that will be used to attain it. This will prevent any confusion or disappointment.

ADJUSTMENT An adjustment is the specific application of forces to facilitate the body's correction of vertebral subluxation. Our chiropractic method of correction is by specific adjustments of the spine.

HEALTH A state of optimal physical, mental and social well-being, not merely the absence of disease.

VERTEBRAL SUBLUXATION A misalignment of one or more of the 24 vertebra in the spinal column which causes alteration of nerve function and interference to the transmission of mental impulses, resulting in a lessening of the body's innate ability to express its maximum health potential.

We do not offer to diagnose or treat any disease or condition other than vertebral subluxation. However, if during the course of a chiropractic spinal examination, we encounter non-chiropractic or unusual findings, we will advise you. If you desire advice, diagnosis or treatment for those findings, we will recommend that you seek the services of a health care provider who specializes in that area.

Regardless of what the disease is called, we do not offer to treat it. Nor do we offer advice regarding treatment prescribed by others. **OUR ONLY PRACTICE OBJECTIVE** is to eliminate a major interference to the expression of the body's innate wisdom. Our only method is specific adjusting to correct vertebral subluxations.

I,_____have read and fully understand the above statements.

All questions regarding the doctor's objective pertaining to my care in this office have been answered to my complete satisfaction.

Therefore, I accept chiropractic care on this basis.

SIGNATURE DATE

Consent to evaluate and adjust a minor child

I,_____being the parent or legal guardian of_____have read and fully understand the above terms of acceptance and hereby grant permission for my child to receive chiropractic care.

Pregnancy Release

This to certify that to the best of my knowledge I am not pregnant and the above doctor and his/her associates have my permission to perform an x-ray evaluation. I have been advised that x-ray can be hazardous to an unborn child. Date of last menstrual cycle. _____

SIGNATURE DATE

OPTIMAL SPINE AND WELLNESS

9630 Ravenna Road
Suite 100
Twinsburg, OH 44087

INSURANCE INFORMATION

PATIENT NAME _____

PRIMARY INSURED'S NAME _____

PRIMARY INSURED'S DATE OF BIRTH _____

PRIMARY INSURED'S SOCIAL SECURITY NUMBER _____

PRIMARY INSURED'S EMPLOYER _____

INSURANCE PLAN NAME _____

INSURED'S ID NUMBER _____

PLAN GROUP NUMBER _____

Patient's or authorized person's signature: I authorize the release of any medical or other information necessary to process my insurance claim. This is to serve as a long-term authorization.

Signed _____ Date _____

Insured's or authorized person's signature:
I authorize payment of medical benefits to Dr. Paul Bizjak or Dr. Andrew Brady for the services described on the insurance form. This authorization is to apply to all occasions of service until it is revoked in writing. I agree to pay for services not covered by insurance and understand that I am ultimately responsible for payment in full at this time.

Signed _____ Date _____