HEATON CHIROPRACTIC CENTER

1406A BELTLINE ROAD DECATUR, AL 35601 (256)-351-8971

DATE: ____________ PATIENT SS #: ________-_____-___________

NAME: ___________________________________ DOB: ___/____/_____

ADDRESS: ____ SEX: M F

CITY: _______________________ STATE: ______ ZIP: __________

HOME #: (_____)-_______________ WORK #: (_____)-_______________

CELL #: (_____)-_______________ EMAIL: ___________________________

(THIS INFORMATION WILL NOT BE SHARED WITH ANYONE)

MARRIED ☐ SINGLE ☐ WIDOWED ☐

PATIENT OCCUPATION: _________________ PATIENT EMPLOYER: ____________

SPOUSE NAME: ______________________ SPOUSE DOB: _____/______/_______

SPOUSE EMPLOYER: ____________________

WHO IS RESPONSIBLE FOR YOUR BILL? SELF ☐ SPOUSE ☐ EMPLOYER ☐ PARENT ☐

WILL WE BE FILING THIS ON INSURANCE FOR YOU? YES ☐ NO ☐

HOW WILL YOU BE PAYING TODAY? CREDIT CARD ☐ CASH ☐ CHECK ☐

IS THIS VISIT A: WORKMAN'S COMP. OR AUTO ACCIDENT

HOW DID YOU HEAR ABOUT OUR OFFICE? _______________________________

DESCRIBE THE TYPE AND FREQUENCY OF YOUR PAIN AS WELL AS THE ACTIVITY THAT BRINGS ON OR AGGRAVATES YOUR PAIN. ***FOR EXAMPLE: DULL, SHARP, CONSTANT, OFF AND ON, WHEN STANDING, SITTING, ETC.***

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PLEASE COMPLETE BACK PAGE

HAVE YOU EVER RECEIVED CHIROPRACTIC CARE? IF SO, LAST DATE: ______/______/_______

NAME OF CHIROPRACTOR: ___________________________

HOW DID THIS CONDITION DEVELOP, WHAT CAUSED IT AND HOW DID IT START? ___________________
____

HOW HAS THIS AFFECTED YOUR:

HOME LIFE? ____

RECREATIONAL LIFE? ____

OCCUPATIONAL LIFE? ____

REST AND SLEEP? ____

HAVE YOU EVER BEEN IN AN AUTOMOBILE ACCIDENT? YES NO PAST YEAR PAST 5 YEARS

ANY MEDICAL DIAGNOSIS OF YOUR COMPLAINT? ____

DRUGS YOU TAKE:

NERVE PILLS MUSCLE RELAXERS TRANQUILIZERSINSULIN BIRTH CONTROL

IF OTHER PLEASE STATE: ____

THIS OFFICE REALIZES THE RESPONSIBILITY OF AIDING THE PATIENT IN THE PROPER HANDLING OF INSURANCE FORMS. HOWEVER PATIENTS ARE HELD DUE AND RESPONSIBLE FOR ANY OFFICE FEES. ***PAYMENT IS DUE AT THE TIME OF SERVICE;*** ARRANGEMENTS CAN BE MADE WITH THE OFFICE ADMINISTRATION IN CASES OF INSURANCE. THIS OFFICE DOES NOT ACCEPT MEDICAID; HOWEVER, WE DO ACCEPT MEDICARE.

I AM AWARE THAT I AM PERSONALLY RESPONSIBLE FOR ALL CHARGES

PRINT NAME: __________________________

SIGN NAME: ___________________________ DATE: ____/_____/______