CROWNE CHIROPRACTIC CLINIC
JERROD EDWARDS, D.C.

Welcome To Our Office

Full Name: _____ □ Male □ Female □ Single □ Married □ Other
Address: _____ Injury/Illness Date: _____
City: _____State:_____ Zip: _____ Date of Birth: _____ Age: _____
Mobile Phone: _____Home Phone: _____ Email: _____
Social Security #: _____ How were you referred?_____

Employer: _____Employer Address:_____
City: _____ State:_____ Zip:_____ Work Phone: _____EXT: _____

Spouse/Partner Name:_____ Date of Birth:_____
Phone Number:_____ Can We Disclose Your Health Information To This Person? □Yes □ No

□Auto Accident □Group Health Insurance □Medicare
Health Insurance _____ Member ID #: _____

Alcohol Use: □ Daily □ Weekly □ Monthly □ Never Tobacco Use: □ Daily □ Weekly □ Monthly □ Never
Have you ever received Chiropractic Care? □Yes □ No If yes, When?_____

1. CHIEF COMPLAINT: _____
_____

When did this begin? _____Have you had this before? □ Yes □ No
Did you hurt yourself? □Yes □ No Is condition getting worse? □Yes □ No How long does it last?_____
Check all that apply: □Dull □Aching □Sharp □Shooting □Burning □Throbbing □Deep □ Nagging □ Tingling □Other
Does the pain radiate or travel to any other areas of your body? _____
Grade Pain: Intensity/Severity: (0-No Pain) 0 1 2 3 4 5 6 7 8 9 10 (10- Max Pain)
Does Anything Aggravate the complaint? _____ Does anything make Complaint better?_____
Previous doctors, treatments, medications, or surgery you have sought for your complaint(s):
_____
_____

2. SECONDARY COMPLAINT(S):_____
_____

3. PAST HEALTH HISTORY:
   A. Previous major illnesses you have had in your life:
   _____
   B. Previous injury or trauma:
   _____
   C. Allergies:_____
   D. Medication you are now taking: □ Other Medications Listed On Back Of This Page
   _____Reason:_____
   _____Reason: _____
   _____Reason: _____
   E. SURGERIES: □ Other Surgeries Listed On Back Of This Page
   Date:_____ Type of surgery:_____
   Date:_____ Type of surgery:_____
   F. FEMALES:
   Pregnancies/Date of Delivery: _____
   What was the date of the beginning of your last menstrual period? _____

4. FAMILY HEALTH HISTORY:
Associated health problems of the father and mother: _____
Deaths in immediate family:_____

Level of education: _____Drug Use: _____Hobbies: _____

2810 South Cooper • Arlington, Texas • 76015 • 817.467.9233 • Fax 817.468.4777
www.crownechiropractic.com

PATIENT AGREEMENT: ASSIGNMENT AND RELEASE

1. Crowne Chiropractic is authorized to release any information they deem appropriate concerning my physical condition to any insurance company, attorney or adjuster in order to process any claim for reimbursement of charges incurred.

2. I hereby authorize the direct payment to Crowne Chiropractic of any sum I now or hereafter owe by my attorney out of any proceeds of any settlement of my case, and by any insurance company obligated to make payment to me or Crowne Chiropractic based in whole or in part upon the charges made for your services.

3. I hereby authorize the use of this signature on all my insurance submissions.

4. I will not settle my case without informing the office in advance of my intention to do so.

5. This office conforms to the current HIPAA guidelines. You may request a copy of our HIPAA policy at the front desk. Please initial to indicate you have been made aware of this availability. _____

6. I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures including various modes of physical therapy, and if necessary, diagnostic x-rays on me (or on the patient named, for whom I am legally responsible: _____) by the chiropractic physician and/or anyone working in this office authorized by the chiropractic physician. I further understand that such chiropractic services may be performed by Dr. Jerrod Edwards and/or other licensed Physicians of Chiropractic who may treat me now or in the future at this office. I have had an opportunity to discuss the nature and purpose of chiropractic adjustments and other procedures. I understand that results are not guaranteed. I understand and am informed that, as in the practice of medicine and all healthcare, the practice of chiropractic carries some risks to treatment; including, but not limited to: fractures, disc injuries, strokes (CVA), dislocations, and sprains. I do not expect the physician to be able to anticipate and explain all risks and complications. Further, I wish to rely on the physician to exercise judgment during the course of the procedure which the physician feels are in my best interests at the time, based upon the facts then known. I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its contents, and by signing below, I agree to the treatment recommended by my physician. I intend this consent form to cover the entire course of treatment for my present condition(s) and for any condition(s) for which I seek treatment at this facility

7. Crowne Chiropractic offers automated appointment reminders via text message and/or email. I agree to this service and understand that it can be cancelled at any time.

8. I have read the above information and certify it to be true and correct to the best of my knowledge.

Patient Name: _____

Patient/Guardian Signature: _____ Date:_____

Mission Statement

CROWNE CHIROPRACTIC CLINIC
JERROD EDWARDS, D.C.

Mission Statement

"To educate and lead as many families as possible toward optimal health through proper nutrition, massage and natural Chiropractic care"

OFFICE POLICY

Welcome to our family. Our goal is to serve this community with exceptionally friendly and prompt service. We want to provide the best health care available for your family. It is our experience that our patients who follow these simple guidelines obtain the best results and greatest benefits to their health. ***Initials***_____

Office Hours:

Monday	9:00am to 1:00pm	3:00pm to 6:00pm
Tuesday	3:00pm to 6:00pm	
Wednesday	9:00am to 1:00pm	3:00pm to 6:00pm
Thursday	9:00am to 1:00pm	3:00pm to 6:00pm
Friday	9:00am to 1:00pm	

Initials_____

Appointment Schedule:

For your convenience and to ensure prompt, reliable service, we request that you pre-schedule all your appointments. We have a specific course of care that requires a number of adjustments in a set amount of time. Please provide a 24 hour notice when rescheduling an appointment so that we may serve others during your appointment time. Please refrain from repeatedly rescheduling. Keeping your appointments is *your* part in the correction of *your* problem and the restoration of *your* health. Therefore, more than three consecutive missed appointments is grounds for dismissal from care. If you are more than 15 minutes late, we reserve the right to reschedule your appointment. As there are only a few massage appointments available each day, a missed hour long appointment is seriously detrimental to our schedule, not to mention to our massage therapist's pocketbooks. After your first missed massage, a charge of $20 will be assessed to your account when a 24 hour notice is not provided if we are unable to fill your reserved time. ***Initials***_____

Children & Family:

Once you understand how the nervous system controls and coordinates all functions in the body and that subluxations interfere with nerve flow, we would expect that you would want everyone in your family checked for subluxation. We have a cost effective family program for you. We will be happy to schedule an appointment for their check-up today. We don't know if they need care, we do know they need to be checked.

Initials_____

Interruption of Care:

In the unlikely event that it is necessary to discontinue care, for any reason, any outstanding fees become due **immediately**. If you, the patient, discontinue care at any time, all fees become payable at the retail fee. If we find the need to dismiss you from care, all fees will be payable at any discounted rate agreed upon. If the care was prepaid, you are entitled to a refund of any unused portion, after all visits are paid at the retail rate.

Initials_____

Chiropractic Excellence:

In order to continue providing the best Chiropractic Care available, our doctors and staff occasionally need to be away from the office to attend conferences and continuing education seminars. So that you may continue your recommended adjustment schedule, another highly qualified doctor may be here to care for you in their absence.

Initials_____

Remember…

Healing and correction takes time. If at any time during your care you do not feel that you are responding as well as you expected, please discuss it with us. We want you to get the most from your Chiropractic care!

Initials_____

Referrals:

The greatest honor a patient can give to us is a referral of their family and friends. We promise to give your loved ones the same quality, love and attention that you receive. We also want to tell you in advance…..THANK YOU!

Treatment Plans

Your treatment plan's discounted price is based off of you completing it. If you choose not to complete the treatment all the way through the refunded charges are the full charge amount not at a discounted rate. All refunds are up to Crowne Chiropractic's discretion. ***Initials*** _____

I have read and understand the above policies and agree to abide by them.

Signed_____**Date**_____

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