MONTGOMERY CHIROPRACTIC

JOIN THE PAIN RELIEF REVOLUTION!

ACCT _____

LRM MRM

PATIENT INFORMATION

Date: _____

Name: (Last) _____ (First) _____ (Middle) _____

SS#:_____ Marital Status: S M D W Birth Date: _____ # of Children: _____

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

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

Phone: (Home) _____ (Cell) _____ (Work) _____

Email: _____

Preferred Communication: Home___ Work___ Cell___ E-mail___ Text Message___

Preferred Language_____

Employer: _____ Occupation: _____

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

Spouse's Name: _____ Birth Date: _____

Spouse's Employer Name and Address: _____ Work Phone: _____

Do you have insurance? Yes___ No___ Company _____ ID_____ Policy/Group _____

Please present ID and Insurance Card for filing purposes.

IN CASE OF EMERGENCY/ RESPONSIBLE PARTY:

Name (Last, First, Middle): _____ Phone: _____

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

Nearest Relative Not Living With You: _____ Phone: _____

Address: _____

Family Physician: _____ Phone: _____

Address: _____

Who may we thank for REFERRING you? (Their Name) _____

Phone Book Newspaper Sign Staff Website Other: _____

CURRENT GOAL FOR HEALTH/WELLBEING (Please fill in a choice):

- ○ I am only concerned about relief of a particular symptom(s)
- ○ I am only concerned about relief of a particular symptom(s), and preventing its/their return
- ○ I want optimum health and wellbeing on every level available to me

Main Complaint: _____ Second Complaint: _____ Third Complaint: _____

Date Began: _____ Date Began: _____ Date Began: _____

Other Care Received For This Condition: _____

What hobby or activity do you want to return to when you recover? _____

Have you ever received Chiropractic Care before? Yes___ No___ Doctor's Name: _____

Doctor's Address: _____ Phone: _____

PERSONAL HISTORY

THE HUMAN BODY IS DESIGNED TO EXPRESS HEALTH AND FUNCTION NORMALLY. HOWEVER, EVENTS MAY OCCUR IN LIFE, WHICH CAN INTERFERE WITH THIS NATURUAL ABILITY.

THIS INTERFERENCE IS MOST COMMONLY THE RESULT OF VERTEBRAL SUBLUXATION

STRESS THAT MAY BE PHYSICAL, CHEMICAL OR EMOTIONAL MAY CAUSE THESES SUBLUXATIONS.

THE PRACTICS OF CHIROPRACTIC IS BASED ON THE LOCATION AND REDUCTION OF NERVE SYSTEM INTERFERENCE CAUSED BY THE VERTEBRAL SUBLUXATION

PLEASE TELL US ABOUT ANY STRESS FROM CHILDHOOD UP TO PRESENT:

Do You Smoke? Yes___ No___ Packs per day? _____

How many alcoholic beverages per week? _____

Are you pregnant? Yes___ No___

Date of last menstrual period? _____

Limited Exercise? Yes___ No___ Describe: _____

Poor Nutrition? Yes___ No___ Describe: _____

Any health related problems? Yes___ No___ Describe: _____

Have you been treated for any health condition in the last year by a physician? Yes___ No___ Describe: _____

_____

Major Illnesses? Yes___ No___ Describe: _____

Reoccurring Illnesses? Yes___ No___ Describe: _____

Work Injury? Yes___ No___ Describe: _____

Sports Injury? Yes___ No___ Describe: _____

Are you allergic to any medication? Yes___ No___ What Kind? _____

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that this office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to this office will be credited to my account upon receipt. I permit this office to endorse co-issued remittances for the conveyance of credit to my account. However, I clearly understand and agree that all services rendered to me are charged directly to me, and that I am personally responsible for payment. I understand that if given the discounted time of service fees, those fees must be paid in full on the same business day or else the time of service fees will be moved to full service fees. It is my understanding that my credit may be checked if Montgomery Chiropractic extends credit to me and I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered to me will be immediately due and payable unless prior arrangements are made. I hereby authorize the doctors at Montgomery Chiropractic and whomever they may designate as their assistants to administer treatment as they so deem necessary, and I also authorize the release of any information acquired in the course of my examination or treatment. I certify that the above information is true and correct.

WE ACCEPT PAYMENT BY CASH, CHECK AND CREDIT CARD

○ I CHOOSE TO DECLINE RECEIPT OF MY CLINICAL SUMMARY AFTER EVERY VISIT (THESES SUMMARIES ARE OFTEN BLAN AS A RESULT OF THE NATURE AND FREQUENCY OF CHIROPRACTIC CARE).

PATIENT SIGNATURE: _____ DATE: _____

Signature of Guardian: _____ DATE: _____