

WELCOME TO OUR OFFICE

TELL US ABOUT YOU

(PLEASE PRINT CLEARLY)

NAME:		SOCIAL SECURITY #:			DATE:	
DATE OF BIRTH:	AGE:	SEX: M F	MARITAL STATUS: M S D W		# OF CHILDREN:	
ADDRESS:						
CITY:			STATE:		ZIP:	
HOME PHONE #:			CELL PHONE #:			
E-MAIL ADDRESS:				OCCUPATION:		
COMPANY NAME:				LENGTH OF EMPLOYMENT:		
TYPE OF WORK:	OFFICE/CLERICAL	LIGHT LABOR	MODERATE LABOR	HEAVY LABOR		
SPOUSES NAME:						
IN CASE OF EMERGENCY CONTACT NAME:				HOME PHONE #:		

TELL US ABOUT YOUR PAST HEALTH

Y	N	Frequent Neck Pain	Y	N	Alcohol / Drug Abuse	Y	N	Stroke
Y	N	Lower Back Pain	Y	N	Hepatitis	Y	N	Heart Surgery / Pacemaker
Y	N	Severe / Frequent Headaches	Y	N	Knee Pain	Y	N	Heart Murmur
Y	N	Peripheral Neuropathy	Y	N	Shingles	Y	N	Congenital Heart Defect
Y	N	Arm / Leg Pain	Y	N	Cancer	Y	N	Mitral Valve Prolapse
Y	N	Arthritis	Y	N	Chemotherapy	Y	N	Artificial Valves
Y	N	Artificial Limbs / Joints	Y	N	Anemia	Y	N	Rheumatic Fever
Y	N	Asthma / Emphysema	Y	N	Difficulty Breathing	Y	N	Diabetes / Tuberculosis
Y	N	Ulcers / Colitis	Y	N	Carpal Tunnel	Y	N	High / Low Blood Pressure
Y	N	Kidney Problems	Y	N	Heart Attack	Y	N	Fractures
Y	N	Workers Comp injuries	Y	N	Personal Injuries	Y	N	Sports or Other Injuries to Head, Neck or Back
Y	N	Hospitalized	Y	N	Chiropractic Care	Y	N	Surgery

PLEASE LIST ANY MEDICATIONS YOU ARE CURRENTLY TAKING:

PLEASE LIST ANY VITAMINS YOU ARE CURRENTLY TAKING:

PLEASE LIST ANY SERIOUS MEDICAL CONDITIONS YOU HAVE EVER HAD:

PRIMARY CARE PHYSICIAN:

PHONE #:

DATE OF LAST DOCTOR VISIT:

LIST ANY THING YOU MAY BE ALLERGIC TO:

LIST PAST SERIOUS ACCIDENTS:

FAMILY HEALTH HISTORY:

DIABETES

CANCER

HEART DISEASE / STROKE

OTHER:

DO YOU SMOKE?

Y N

HOW LONG?

PACKS PER DAY:

ALCOHOL CONSUMPTION?

NEVER

SOCIAL

LIGHT

MODERATE

HEAVY

FOR WOMEN ONLY

DO YOU TAKE BIRTH CONTROL?

Y N

IF YES, FOR HOW LONG?

ARE YOU NURSING?

Y N

ARE YOU PREGNANT

Y N

DELIVERY DATE?

AUTHORIZATIONS:

A. I hereby authorize release of any medical information necessary to process this claim and request payment of insurance benefits either to myself or to the party who accepts assignment.

B. I authorize payment of any medical benefit from third-parties for benefits submitted for my claim to be paid directly to this office. I authorize the direct payment of this office of any sum I now or hereafter owe this office by my attorney, out of proceeds of any settlement of my case and by any insurance company contractually obligated to make payment to me or you based upon the charges submitted for products and services rendered.

C. I understand and agree that health and accident 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. 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 also understand that if I suspend or terminate my care and treatment, any fees for products or professional services rendered will be immediately due and payable.

We invite you to discuss with us any questions regarding our services and or fees. The best health services are based on a friendly, mutual understanding between provider and patient.

I understand the above information and guarantee this form was completed correctly to the best of my knowledge. I understand it is my responsibility to inform this office of any changes in my medical or insurance status.

INSURANCE INFORMATION

WHO IS RESPONSIBLE FOR THIS ACCOUNT:	
INSURANCE COMPANY:	PHONE #:
GROUP #:	ID #:

Signature _____ **Date** _____

Guardian Signature _____ **Date** _____

WHOM MAY WE THANK FOR REFERRING YOU TO OUR OFFICE?
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