Confidential Patient Information

Name: _____ Hm Phone: _____ Wk/Cell Phone: _____

Address: _____ City: _____ St: _____ Zip: _____

Date of Birth: _____ Marital Status (circle one) M S D W Age _____

Social Security Number _____-____-_____ E-mail Address _____

Occupation: _____ Employer: _____

Work Address: _____ City, St, Zip: _____

Name of Spouse: _____ # of Children: _____

Who may we thank for referring to our office: _____

Have you ever had Chiropractic care before? Yes ( ) No ( ) Date: _____

Is this injury/illness related to: Automobile Accident Yes ( ) No ( )

Date/Time: _____ Location: _____

Your Auto Insurance Co: _____ Phone: _____

Third Party Auto Insurance Co: _____ Phone: _____

Due to changes in health insurance fees, patient self-billing has become a much more cost effective way for you, the patient, to get reimbursement for your care. Self-billing allows us to keep our fees low so you can get the care you need without any added cost. Therefore, our policy is that all payment is due at the time of service and bills will no longer be sent to your insurance provider. Statements will be provided for individuals to submit their own bills ensuring that as your insurance provider pays for your care, they will send the reimbursement check directly to you.

All charges are due when services are renderedé

Method of payment ( ) Check ( ) Cash ( ) Credit Card ( ) Care Credit

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Why Chiropractic? People go to Chiropractors for a variety of reasons. Some go for symptomatic relief of pain or discomfort (Relief Care). Others are interested in having the cause of the problem as well as the symptoms corrected and relieved (Corrective Care). Your Doctor will weigh your needs and desires when recommending your treatment program.

Relief Care

Relief Care is that care necessary to get rid of your symptoms or pain, but not the cause of it. It is the same as drying a floor that was getting wet from a leak, but not fixing the leak.

Corrective Care

Corrective care differs from relief care in that its goal is to get rid of the symptoms or pain while correcting the cause of the problem. Corrective care varies in length of time, but is more lasting.

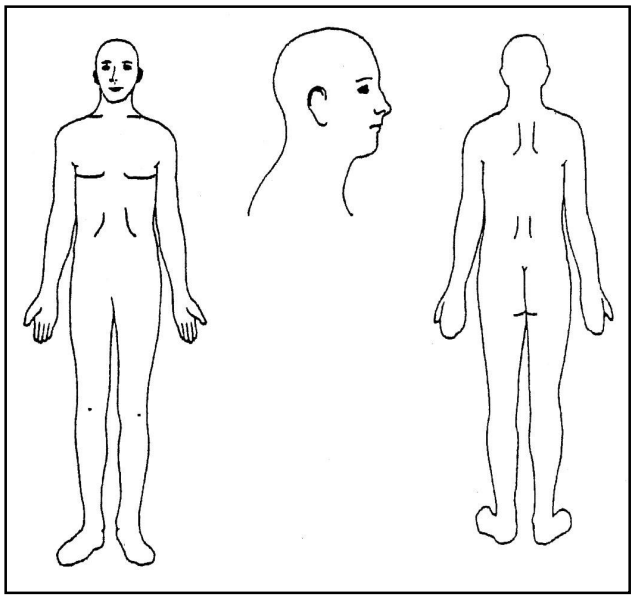
I authorize the service provider to render necessary services to me and I am responsible for all charges incurred.

Patient Signature: _____ Date: _____

Parent or Legal Guardian Authorizing Care: _____

Thank You For Allowing Us To Serve You!

PLEASE MARK AN X ON THE DIAGRAM BELOW WHERE YOUR PROBLEMS ARE



What hurts and how long has it hurt?

1. _____
2. _____
3. _____
4. _____

When do you think these problems originally started?

1. _____
2. _____
3. _____
4. _____

List other Chiropractic or Medical Doctors you have consulted for these conditions.

1. _____
2. _____
3. _____
4. _____

Check any of the following you have had in the last six months:

( ) Headaches
( ) Sinus Congestion / Allergies
( ) Vision Problems
( ) Ear Aches
( ) Dizziness
( ) Heart Problems
( ) Lung Problems / Congestion
( ) Blood Pressure Problems
( ) Ankle Swelling
( ) Prostate / Sexual Dysfunction
( ) Menstrual Cycle Dysfunction
( ) Numbness
( ) Frequent Nausea / Vomiting
( ) Abdominal Cramps
( ) Constipation
( ) Diarrhea
( ) Poor / Excessive Appetite
( ) Excessive Thirst
( ) Painful / Excessive Urine
( ) Discolored Urine
( ) Diabetes
( ) Cancer

Are you pregnant? ( ) Yes ( ) No ( ) Not Sure