

PATIENT INFORMATION

First Name: _____ MI: _____ Last Name: _____
Street: _____ Apt: _____
City: _____ State: _____ Zip: _____
Social Security #: _____ Marital Status: S M W D Spouse: _____
DOB: _____ Home Phone: _____ Work Phone _____
Cell Phone: _____ E-mail: _____
Occupation: _____ Employer: _____
Employer Address: _____
Emergency Contact _____ Phone # _____

INSURANCE INFORMATION

We will make a copy of your insurance card/s. However, please complete the following information.

Are you the policy holder? Y N If no, who is the policy holder: Spouse Parent Employer Other

Policy Holder's Name:

First Name: _____ MI: _____ Last Name: _____

Policy Holder's DOB: _____ Policy Holder's SS#: _____

Policy Holder's Employer: _____

Do you have secondary insurance coverage? Y N If yes, please complete the following:

Policy Holder's Name:

First Name: _____ MI: _____ Last Name: _____

Policy Holder's DOB: _____ Policy Holder's SS#: _____

Policy Holder's Employer: _____

ASSIGNMENT & RELEASE

Insurance Information

I understand and agree that health and accident insurance policies are an agreement 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 doctor's 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 or outstanding balances for services rendered will be immediately due and payable.

Patient, Parent, or Guardian Signature: _____

Consent of Professional Services and Release of Information

I hereby authorize and release the doctor and whomever he/she may designate as his/ her assistants to administer treatment, physical examination, x-ray studies, laboratory procedures, chiropractic care or an clinic services that he/she deems necessary in my case; I furthermore authorize him/her to disclose all or any part of my patient record to any person or corporation which is or may be liable under a contract to this office or to the patient or to a family member or employer of the patient for all or part of the clinic's charge, including and not limited to hospital or medical service companies, insurance companies, worker's compensation carriers, welfare funds, or the patient's employer.

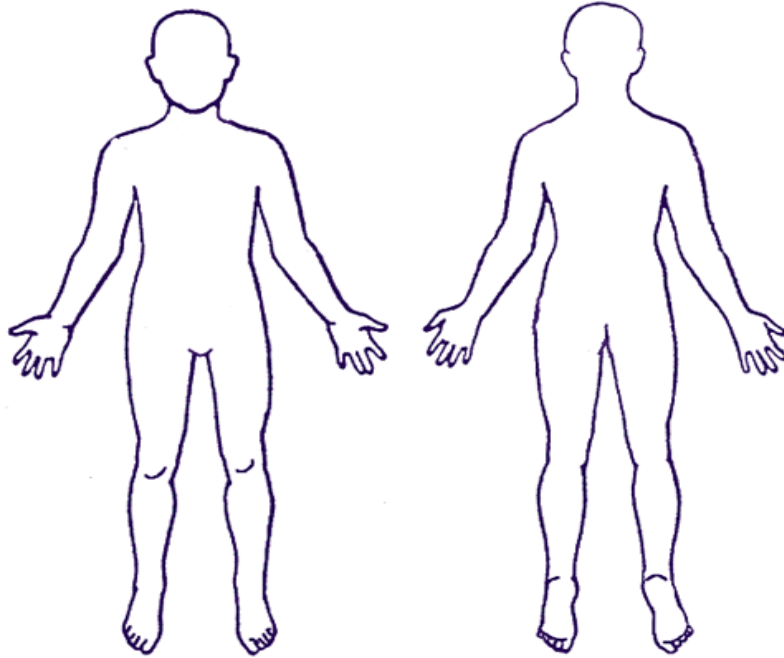
Patient, Parent or Guardian Signature: _____

1. What other treatment have you already received for your condition?

Medications Surgery Physical Therapy Chiropractic None

2. Name of other doctor(s) who have treated your condition: _____

3. Place an X where you are having pain:



FRONT

BACK

4. Circle Y (Yes) or N (No) if you have ever or currently are suffering from the following:

- | | | |
|----------------------------|-----------------------------|---------------------------|
| Y N....AIDS/HIV | Y N....Osteoporosis | Y N....Hernia |
| Y N....Alcoholism | Y N....Pacemaker | Y N....Herniated Disk |
| Y N....Allergy Shot | Y N....Parkinson's Disease | Y N....Herpes |
| Y N....Anemia | Y N....Pinched Nerve | Y N....High Cholesterol |
| Y N....Anorexia | Y N....Pneumonia | Y N....Kidney Disease |
| Y N....Appendicitis | Y N....Polio | Y N....Liver Disease |
| Y N....Arthritis | Y N....Prostrate Problems | Y N....Measles |
| Y N....Blood Disorders | Y N....Prosthesis | Y N....Migraine Headaches |
| Y N....Breast Lump | Y N....Psychiatric Care | Y N....Scarlet Fever |
| Y N....Bronchitis | Y N....Rheumatoid Arthritis | Y N....Stroke |
| Y N....Bulimia | Y N....Rheumatic Fever | Y N....Suicide Attempt |
| Y N....Cancer | Y N....Emphysema | Y N....Thyroid Problems |
| Y N....Cataracts | Y N....Epilepsy | Y N....Tonsillitis |
| Y N....Chemical Dependency | Y N....Fractures | Y N....Tuberculosis |
| Y N....Chicken Pox | Y N....Glaucoma | Y N....Tumors/Growths |
| Y N....Diabetes | Y N....Goiter | Y N....Typhoid Fever |
| Y N....Miscarriage | Y N....Gonorrhea | Y N....Ulcers |
| Y N....Mononucleosis | Y N....Gout | Y N....Vaginal Infections |
| Y N....Multiple Sclerosis | Y N....Heart Disease | Y N....Venereal Diseases |
| Y N....Mumps | Y N....Hepatitis | Y N....Whooping Cough |