

APPLICATION FOR TREATMENT

Date _____
Name _____ Age _____ Birthdate _____
Address _____ City _____ State _____ ZIP _____
Home Phone _____ Phone at Work _____ Cell Phone _____
E-Mail Address _____
May we contact you via e-mail for monthly newsletters and/or announcements? Yes No
Whom should we thank for the Referral? _____
Circle if you are: Married Single Widowed Divorced Separated
Employer _____ Occupation _____
•Please describe the main reason(s) for which you came to this office. _____
•On a scale from 0-10, with 10 being unbearable pain, how severe is your pain? 0 1 2 3 4 5 6 7 8 9 10
• When and how did symptoms first occur? _____

•List any other doctors seen for these problems _____

•List diagnosis(es) and type of treatment(s) _____

• Does this interfere with your normal living and work? Yes No If yes, In what way? _____

•Have you lost any days of work? Yes No Dates _____

•Have you had similar symptoms or injuries before? Yes No If yes, explain _____

•List the names of any relatives that have or have had a similar problem _____

•Who is responsible for your bill (please circle)? Self Spouse Employer Insurance Other _____

PAST HISTORY

•Has a physician treated you for any health condition in the last year? Yes No If yes, explain: _____

•Have you or any relative received Chiropractic treatment previously? Yes No If yes, explain: _____

•List the approximate dates of any operations, unusual diseases, serious illnesses or accidents you have had (include any broken bones) _____

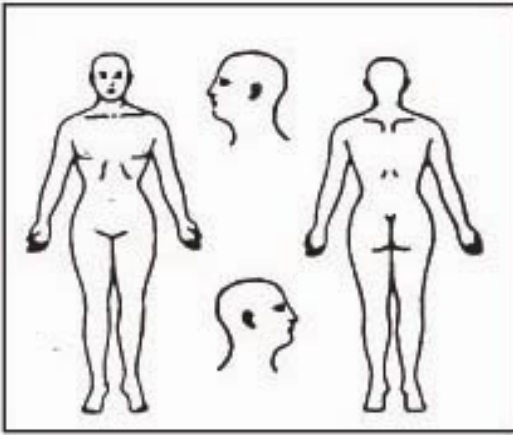
•List all drugs or medication that you have used recently (i.e., aspirin, sleeping pills, birth control pills, etc.) _____

FAMILY CONTACTS

Name of wife or husband _____	Ages of children _____
Spouse's Employer _____	Business Phone _____
Your Nearest Relative _____	
Relative's Address _____	Phone Number _____

PLEASE TURN OVER
CURRENT CONDITION

Please mark your areas of pain on the figures below.



List the conditions that you are most interested in getting corrected. List in order of importance:

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

What functions are you unable to perform or induce pain upon performance? List in order of severity. (Example: sitting, walking, bending, lying down)

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

CONSENT TO RECEIVE TREATMENT

FEES ARE PAYABLE AT THE TIME X-RAYS, EXAMINATIONS AND TREATMENTS ARE RECEIVED UNLESS OTHER ARRANGEMENTS ARE MADE IN ADVANCE. X-RAYS REMAIN THE PROPERTY OF THIS CLINIC. I HEREBY GIVE PERMISSION FOR TREATMENT.

Signature of Patient _____ **Social Security Number** _____

Date _____

INSURANCE INFO

Patient's or Authorized Person's Signature: I authorize the release of any medical or other information necessary to process my insurance claim. This is to serve as a long-term authorization card. I authorize payment of medical benefits to Rabines Chiropractic, PC for the services described on the insurance form. This authorization is to apply to all occasions of service until it is revoked in writing.

Signature _____ Date _____

MEDICARE ONLY

All doctors have been instructed to ask the following questions of all Medicare patients. (PLEASE CIRCLE)

1. Do you or your spouse work for a company that provides you with health insurance? **Yes** **No**
2. Are you entitled to Medicare because of End Stage Renal Disease? **Yes** **No**
3. Is this illness or injury the result of an accident or other injury? **Yes** **No**
4. Is this illness or injury the result of an accident or illness that occurred at work? **Yes** **No**
5. Has the treatment for this accident or illness been authorized by the Veteran's Administration? **Yes** **No**
6. Are you entitled to any benefits under the Federal Black Lung Program? **Yes** **No**
7. Do you have a Medicare Medigap Policy? **Yes** **No**
8. Do you have a Medicare Supplement Policy? (Policy provided by employer you retired from) **Yes** **No**

Signature _____ Date _____

