Employer Data

Name: ____

Address Line 1: ____________________________________

Phone Number: ____________________________________

City: _______________________________ **State:** ___________________ **Zip Code:** __________________

Spouse Data

Is your spouse a patient in the clinic? ☐Yes ☐ No

First Name: _________________________ **Middle Initial:** _____ **Last Name:** ________________________

Home Phone: (_____)________-_____________ **Work Phone:** (_____)________-_____________

Emergency Contact

Contact Name:____

Contact Phone: (_______) ________-_______________

Insurance Information

Who is responsible for this account:____

Subscriber's Name: ____

Date of Birth: ____

ASSIGNMENT AND RELEASE:

I certify that I and /or my dependent(s) have insurance coverage with (Name of Insurance Company (ies) _______________________ and assign directly to Dr. Timmerman all insurance benefits if any otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance situations. The above named doctor may use my health care information and may disclose such information to the above name insurance Company (ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefit payable for related services. This consent will end one year from the date signed below.

Signature of Patient, Parent, Guardian or Personal Representative: _______________________________

How did you hear about our clinic? Or who referred you?

- ❑ Family member
- ❑ Attorney
- ❑ Internet web site
- ❑ Health class
- ❑ Friend
- ❑ Yellow Pages
- ❑ Billboard
- ❑ Brochure
- ❑ Physician
- ❑ Newspaper ad
- ❑ TV Commercial
- ❑ Direct mail ad
- ❑ Employer
- ❑ Sign on building
- ❑ Radio
- ❑ Other

If you selected 'family member', 'friend', or 'physician' please enter their name below:

____

Medical Conditions:

- ❑ Arthritis
- ❑ Cancer
- ❑ Diabetes
- ❑ Heart Disease
- ❑ Hypertension
- ❑ Psychiatric Illness
- ❑ Skin Disorder
- ❑ Stroke

Surgeries:

- ❑ Appendectomy
- ❑ Cardiovascular procedure
- ❑ Cervical disc procedure
- ❑ Hysterectomy
- ❑ Joint replacement
- ❑ Laminectomies
- ❑ Radical prostatectomy
- ❑ Transuretheral prostate surgery

Allergies:

- ❑ Eggs
- ❑ Fish and Shellfish
- ❑ Milk or Lactose
- ❑ Peanut
- ❑ Soy
- ❑ Sulfites
- ❑ Wheat/Gluten

Social History:

- ❑ Caffeine used occasionally
- ❑ Caffeine used often
- ❑ Chew tobacco occasionally
- ❑ Chew tobacco often
- ❑ Drink alcohol occasionally
- ❑ Drink alcohol often
- ❑ Exercise not at all
- ❑ Exercise occasionally
- ❑ Exercise often
- ❑ Experience stress occasionall
- ❑ Experience stress often
- ❑ Smoke 1 pack or less per day
- ❑ Smoke more than 1 pack a day
- ❑ Wear seat belts always
- ❑ Wear seat belts never
- ❑ Wear seatbelts usually

Family History:

- ❑ Arthritis (parent)
- ❑ Arthritis (sibling)
- ❑ Cancer (parent)
- ❑ Cancer (sibling)
- ❑ Cholesterol (parent)
- ❑ Cholesterol (sibling)
- ❑ Diabetes (parent)
- ❑ Diabetes (sibling)
- ❑ Heart problems (parent)
- ❑ Heart problems (sibling)
- ❑ High blood pressure (parent)
- ❑ High blood pressure (sibling)
- ❑ Psychiatric (parent)
- ❑ Psychiatric (sibling)
- ❑ Stroke (parent)
- ❑ Stroke (sibling)
- ❑ Thyroid (parent)
- ❑ Thyroid (sibling)

Family Doctor:____

Describe your symptoms:____

____

When did your symptoms start? Month____________________ **Day**________________ **Year**_______________

How did your symptoms begin?____

____

How often do you experience your symptoms?

- ❑ Constantly (76-100% of the day)
- ❑ Frequently (51-75% of the day)
- ❑ Occasionally (26-50% of the day)
- ❑ Intermittently (0-25% of the day)

What describes the nature of your symptoms?

- ❑ Sharp
- ❑ Dull ache
- ❑ Numb
- ❑ Shooting
- ❑ Burning
- ❑ Tingling
- ❑ Stabbing

How are your symptoms changing?

- ❑ Getting better
- ❑ Not changing
- ❑ Getting worse

During the past 4 weeks, indicate the average intensity of your symptoms: (0 = None to 10 = Unbearable)

- ❑ 0 None
- ❑ 1
- ❑ 2
- ❑ 3
- ❑ 4
- ❑ 5
- ❑ 6
- ❑ 7
- ❑ 8
- ❑ 9
- ❑ 10 Unbearable

Who have you seen for your symptoms:

- ❑ No one
- ❑ Other Chiropractor
- ❑ Medical Doctor
- ❑ Physical Therapist
- ❑ Other

What treatment did you receive for your symptoms?

- ❑ Adjustments
- ❑ Physical Therapy
- ❑ Medication
- ❑ Surgery
- ❑ Other

When did you receive this treatment?

- ❑ In the last month
- ❑ 2 – 3 months ago
- ❑ 3 – 6 months ago
- ❑ 6 months to 1 year ago
- ❑ 1 – 2 years ago
- ❑ 2 – 5 years ago
- ❑ 5 – 10 years ago

What tests have you had for your symptoms?

- ❑ X-rays
- ❑ MRI
- ❑ CT Scan
- ❑ Other

When were these tests done?

- ❑ In the last month
- ❑ 2 – 3 months ago
- ❑ 3 – 6 months ago
- ❑ 6 months to 1 year ago
- ❑ 1 - 2 years ago
- ❑ 2 – 5 years ago
- ❑ 5 – 10 years ago

If you have seen treatment in the past for the same or similar symptoms, who did you see?

- ❑ This Office
- ❑ Other Chiropractor
- ❑ Medical Doctor
- ❑ Physical Therapist
- ❑ Other

INFORMED CONSENT WAIVER & AUTHORIZATION TO TREAT

I the undersigned, acknowledge by my signature, that I am aware that Dr. David Timmerman is a licensed Chiropractic Physician and although very rare, injury from treatment or manipulation may have adverse effects. These may include or be associated with stroke, disc herniation, muscle strains or other injuries or complications.

Signature: ________________________________ **Date:** _____________

****In order to protect you from identity theft, The Federal Trade Commission requires our office to obtain your social security number and a copy of your valid state/government issued ID to comply with The Fair and Accurate Credit Transactions Act (FACT Act) of 2003.**

Please give our receptionist your insurance card so that we may copy it for our records and verify your coverage. Thank you