

Please allow our staff to photocopy your driver's license and all available insurance cards.

WELCOME! PLEASE PRINT.

Full Name _____ Gender: **M** **F** Home Phone _____

Address _____ City _____ State _____ Zip _____

Age _____ Birth Date _____ Marital Status (Circle One): **S** **M** **W** **D** **Sep** No. Children _____

SS# _____ Email Address _____

Your Employer _____ Your Occupation _____ Years on Job _____

Employer Address _____ City _____ State _____ Zip _____

Work Phone _____ Cell Phone _____

Do you have health insurance where you work? Yes No Plan/Group # _____

Insurance Company _____

Name of Spouse, Parent or Guardian _____ Age _____ Birth Date _____ SS# _____

Spouse's Employer _____ Spouse's Occupation _____ Years on Job _____

Employer Address _____ City _____ State _____ Zip _____

Work Phone _____

Does your spouse have health insurance at work? Yes No Plan/Group # _____

Insurance Company _____

How did you find out about our office? _____

Describe the major complaints that bring you to our office: _____

Is your condition due to an accident? Yes No Date of your accident: _____

I (we) agree to pay for services rendered to the above-mentioned patient as the charge is incurred. I (we) understand that health and accident insurance policies are arrangements between an insurance carrier and myself and that I am personally responsible for payment of any and all services, covered or non-covered. If the doctor is a contracted provider for my managed care plan, I understand I am responsible for all copayments and non-covered services. I also understand and agree to pay all copays and fees for non-covered services prior to seeing the doctor. I understand that if I terminate my care and treatment, any fees for professional services rendered me will be immediately due and payable. I understand that unpaid fees for services beyond thirty (30) days are subject to a 1.5% monthly finance charge (18% annually).

I (we) authorize the doctor and his staff to release any information deemed appropriate concerning my physical condition to any insurance company, claims adjuster, case nurse, claims reviewer, employer, health care provider or attorney in order to process any claim for reimbursement or charges incurred by me as a result of professional services rendered and hereby release him/her of any consequences thereof. I agree that a photostatic copy of this agreement shall serve as the original.

I (we) hereby authorize and direct payment of any medical/chiropractic expense benefits allowable to the doctor as payment toward the total charges for professional services rendered. This payment will not exceed my indebtedness to the assignee. I agree that a photostatic copy of this agreement shall serve as the original.

Patient's Signature _____ Date _____

Spouse's or Guardian's Signature _____ Date _____

We file your primary insurance at no charge to you. Filings for policies in addition to your primary coverage are completed *for a fee and as time permits*.

Payment Options (Please Indicate): Cash Check MasterCard Visa Discover

Please answer the questions below concerning your health history. Be sure to list all conditions or symptoms, both past or present.

An understanding of your health history will help us to determine appropriate care.

FULL NAME _____ DATE _____

AGE _____ RACE _____ GENDER _____ HEIGHT _____ WEIGHT _____

Review of Systems

1. Do you have skin, hair or nail problems? Yes No _____
2. Do you have mouth and/or throat problems? Yes No _____
3. Do you have nose and/or sinus problems? Yes No _____
4. Do you have ear problems? Yes No _____
5. Do you have eye problems? Yes No _____
6. Do you have chest or lung (breathing) problems? Yes No _____
7. Do you smoke? Yes No Amount per day _____ How Long? _____
8. Do you have heart and/or blood vessel problems? Yes No _____
9. Do you have blood or lymph node problems? Yes No _____
10. Do you have digestive problems? Yes No _____
11. Do you have genital problems (e.g. prostate, testicular, vaginal)? Yes No _____
12. Do you have urinary (including kidney or bladder) problems? Yes No _____
13. **Females**, have you had menstrual problems? Yes No _____
 Have you ever taken birth control pills? Yes No For how long? _____
 Is there any chance that you are currently pregnant? Yes No
 Do you have any breast problems? Yes No _____
14. Do you have any nervous system diseases and/or mental health problems? Yes No _____
15. Do you have any gland and/or hormone problems? Yes No _____
16. Do you have allergy or immunity problems? Yes No _____
17. Do you have any muscle, tendon or ligament problems? Yes No _____
18. Do you have any bone or joint diseases (examples: bone = osteoporosis, joint = arthritis)? Yes No _____

Past History

19. List any diseases which you have had in the past, including childhood diseases: _____

20. Tell us if you have ever been diagnosed as having a particular condition such as diabetes, cancer, AIDS, etc.: _____

21. Have you suffered any physical injuries such as falls or blows, automobile accidents, whiplash, concussion or head injury, lacerations, sprains, strains, dislocations, broken or cracked bones? Yes No

22. List any surgeries you have had (don't forget appendix, tonsils, ear tubes, wisdom teeth):
 _____ Date _____
 _____ Date _____
 _____ Date _____
 _____ Date _____

(OVER PLEASE)

FULL NAME _____

DATE _____

23. Have you ever been hospitalized for any reason other than surgery? Yes No _____24. **Medications:** Please list all medications (prescription & non-prescription) you are currently taking or take on an occasional basis: _____
_____25. Your diet is: Balanced Fair Poor Excessive Restricted**Family History**26. Are there any diseases or conditions that are common among your family members (i.e. inherited diseases or conditions)? Yes No _____**Social History**27. In what position do you usually sleep, and how well? _____
_____28. Do you exercise on a regular basis? Yes No How? _____

29. How do you spend your spare time (hobbies, etc)? _____

30. Do you use: Caffeine? Tobacco? Nicotine? Recreational Drugs? Alcohol?

31. Please describe your work.

Type: Professional Physical Labor Driver Clerical Factory HomemakerPhysical Demands: Heavy Moderate Mild SedentaryStress Level: High Medium Low**Additional Questions**32. Do you have problems with recurring headaches? Yes No _____33. Are you losing weight without trying? Yes No34. Does your pain wake you up at night? Yes No35. Have you had a change in bowel or bladder habits? Yes No _____36. Have you had a sore that doesn't heal? Yes No _____37. Have you recently had any unusual bleeding or discharge? Yes No _____38. Do you have a thickening/lump in the breast or elsewhere? Yes No _____39. Do you have indigestion or difficulty swallowing? Yes No _____40. Have you had an obvious change in a wart or mole? Yes No _____41. Do you have a nagging cough or hoarseness? Yes No _____42. In the space below, please explain or give additional details regarding the information you have given above. Also, if there is any information about your health history which was not requested, please fill it in below.

_____43. Please describe your current complaint. In other words, what brought you here? _____

44. Who is your:

Medical Doctor? _____

OB/GYN? _____

Dentist? _____