

-----PERSONAL HISTORY-----

Name: _____ Address: _____
City, State, Zip: _____ Home Phone: _____ Sex: __M__F
Birth Date: _____ Driver's License #: _____ Social Security #: _____
Circle One: Married Single Divorced Widowed Children & Ages: _____
E-Mail: _____ Employer: _____ Work Phone: _____
(Only used for Health Newsletter and Reminders)
Spouse Name: _____ Spouse Employer: _____ Spouse SS #: _____
Emergency Contact Name, Phone, and Relationship: _____
How were you referred to this office? _____

-----CURRENT HEALTH CONDITION-----

Purpose of this appointment: _____
Is this condition: __Job Related __Auto Accident __Sports Injury __Chronic __Other: _____
When and How did it begin? _____
Has this Condition occurred before? __No __Yes If Yes, when? _____
What treatments or activities make it better? _____
What treatments or activities make it worse? _____
Family Doctor Name: _____ May we contact your family doctor if necessary? __Yes __No
Medications or Supplements taken? _____
Major Surgeries or Hospitalizations: _____
Previous Chiropractic Care: __None __Doctor's name and last visit _____

-----WHY CHIROPRACTIC?-----

People go to chiropractors for a variety of reasons and there are different levels of care. Please check the type of care desired so that Dr. Smith may be guided by your wishes whenever possible.

- Stage 1 __ Pain relief: Just get rid of the pain, Doc! Relief is short-term.
- Stage 2 __ Rehabilitation: Get rid of the pain, Doc, but then fix this problem so that it doesn't come back!
- Stage 3 __ Optimal Health: Get rid of the pain, fix the problem, and then put me on a preventive maintenance plan which includes diet, exercise and chiropractic so that I stay as healthy as possible.

-----FINANCIAL POLICY AND PATIENT SERVICE AGREEMENT-----

Who is responsible for your bill? You and: __Worker's Comp __Auto Ins. __Medicare __Health Insurance

In order to receive the best care possible within your maximum benefits, it is important that you comply with our financial policy:

1. **Payment is expected at the time of service** in the form of a deductible, copayment, or coinsurance payment. **It is illegal to waive these fees.**
2. Your policy is a contract between you and the insurance company and you are responsible for any unpaid or denied claim, and for any collection fees, court costs, and attorney's fees if your account is turned over for collection.
3. If your insurance company sends you checks, it is your responsibility to deliver them to our office within 5 (five) days.
4. Affordable payment plans or hardship forms are available in special cases.
5. **Cancellations** must be made with **12 hours' notice** or you will be charged for an office visit on the third occurrence.

"I hereby authorize you to furnish information to my insurance company concerning my care. I further hereby assign all insurance payments for chiropractic services rendered to me or my dependents by Dr. Smith, to Dr. Smith."

I have read and understood the above statements.

Signed _____ Date _____
Patient or responsible party