Brookville Chiropractic Center
582 Upper Lewisburg-Salem Rd. Brookville, OH 45309
(937) 833-4200 (p) ~ (937) 833-3444 (f)

Date: ____________________

Confidential Patient Information

Patients Name: ________________________________ Chief Complaint: __________________________________

Address: _____________________________________ Home Phone: _____________________________________

City: _______________________ Zip:__________ Cell Phone: ____

SS#: ____ Email: ____

Date of Birth: ___________________Age:_________ Marital Status: M S W D # of Children:__________

Occupation: __________________________________ Employer: ____

Address of Insured (if different than above): ____

Are your present systems or condition related to, or the result of an auto collision, work-related injury or other personal injury? (Someone else might be responsible for payment?) ___ Yes ___No

Ins. Company: ________________________________ Ins. Phone #: ______________________________________

ID#: ____ Group #: ____

Name of Policy Holder: _________________________ Policy Holder DOB: _________________________________

Policy Holders Employer: ____

Family Physician: ____ (Note: May we send your health information to this provider **Y / N**)

Person to contact in case of emergency (Name and Phone): ____

Have you ever been under Chiropractic Care? Y N If so, Who & When? ____

Have you had any SPINAL X-Rays / MRI's / CT's taken in the last year? Y N If so, Where? ___________________________

What operations have you had? ____ When? ________________

Serious Illness: ____ When? ________________

Infectious Diseases: ____ When? ________________

Do you have a pace maker? **Y / N** Have you ever had any Hip or Knee Replacements **Y / N**

Are or were you a smoker? **Y / N** If yes, for how long?________________ When did you quit?____________

What medications or drugs are you taking? (check those that apply): Pain Killers ____ Insulin _____ Cholesterol Meds ________
Blood Pressure Meds ___ Muscle Relaxers ___ Birth Control ___ Other: __________________________________

Do you have a Family History of:
Mother's Side: Cancer____ Type:________ Diabetes: Type 1____ Type 2____ Stroke ____ Cardiovascular____ Other__________
Father's Side: Cancer ____ Type:________ Diabetes: Type 1____ Type 2____ Stroke ____ Cardiovascular____ Other__________

What is your goal in our office? ____

LEGAL ASSIGNMENT OF BENEFITS AND RELEASE OF MEDICAL AND PLAN DOCUMENTS

In considering the amount of medical expenses to be incurred, I, the undersigned, have insurance and/or employee health care benefits coverage with the above captioned, and hereby assign at clinic's request, and convey directly to **Brookville Chiropractic Center** all medical benefits and/or insurance reimbursement, if any, otherwise payable to me for services rendered from such doctor and clinic. I understand that I am financially responsible for all charges regardless of any applicable insurance or benefit payments. I hereby authorize the doctor to release all medical information necessary to process this claim. I hereby authorize any plan administrator or fiduciary, insurer and my attorney to release to such doctor and clinic any and all plan documents, insurance policy and/or settlement information upon written request from such doctor and clinic in order to claim such medical benefits, reimbursement or any applicable remedies. I hereby authorize the doctor to release any and all medical information to other healthcare providers involved in my care including but not limited to my primary care physician. I authorize the use of this signature on all my insurance and/or employee health benefits claim submissions.

This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original. I have read and fully understand this agreement.

______________________________________ ____________________

Signature of Insured / Guardian Date