PATIENT CASE HISTORY

Date_____

Patient Name_____ Birthdate_____

Address_____ City_____ Zip_____

SS#_____ HM Phone_____

Employer_____ WK Phone_____

Drivers license number_____ State_____

Name of Spouse_____ SS#_____

Spouse's Employer_____

Nearest Relative Not Living with you_____

Who may we thank for referring you_____

TYPE of account: ___ Medicare ___ Medicaid ___ Cash

___ Insurance (name of carrier)_____

___ Auto Accident / DOI_____ (please see other form)

___ Work Related / Claim#_____ / MCO_____

Did your present complaints start:

___ Suddenly ___ Gradually ___ Ongoing ___ Unknown

Please explain what happened to cause your present condition or symptoms:

_____

_____

_____

Date of Onset_____

Are you here for relief from pain only? ___Yes ___No

Are you familiar with wellness care and its benefits? _____

Consent of professional services and Release of information

I hereby authorize and release the doctor and whomever he may designate as his assistants, to administrator treatment, physical examination, x-ray studies, laboratory procedures, chiropractic care or any clinical services that he deems necessary in my case. I further authorize him to disclose all or part of my patient record to any person or corporation which is or may be liable under a contract to the clinic or to the patient or to a family member or employer of the patient for all or part of the clinic's charges, including but not limited to hospital or medical service companies, workers" compensation carriers, welfare funds or the patients employer.

Risk of Treatment

Those physicians using manual medicine (medical doctors, osteopaths, chiropractors and physical therapists) when treating neck injuries are required to inform the patient of the rare instance of injury to the vertebral artery which can cause stroke like symptoms. The instance is approximately one in two million. The appropriate tests will be preformed on you to minimize this risk.

Insurance Information

I understand and agree that health and accident insurance policies are an agreement between an insurance carrier and myself. Furthermore, I understand that this chiropractic office will prepare any necessary forms to assist me in making collection from the insurance company and that any amount will be credited to my account upon receipt. However, I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered to me will be immediately due and payable. I understand that if my account would happen to be forwarded to collection, I will be responsible for all collection and legal fees. I hereby authorize the Assignment of Benefits for payment to this office from any involved carriers for payment of services rendered to me.

Patient's Signature_____

Patient or Guardian Signature_____