INFORMATION/APPLICATION FOR CARE

The following information is needed in order to better serve you. Please complete all questions. If you need help please ask the receptionist. **PLEASE PRINT.** **Today's Date** _____

Name _____ **E-Mail Address** _____

Home Phone _____ **Work Phone** _____**Cell Phone** _____

Preferred Appointment Reminder (CIRCLE): TEXT (Provider is_____) EMAIL PHONECELL/PHONE HOME

Mailing Address _____ **City** _____ **State** _____ **Zip** _____

Age _____ **Birth date** _____ **Marital Status: S M W D Number of Children** _____

Gender: M F Race/Ethnicity: White Black Hispanic Asian/Pacific Islander Native American Other

Please circle one payment type: Cash Check Credit/Debit Driver's License # _____

Your Employer _____ **Occupation** _____ **Years on Job** _____

Employer Address _____ **City** _____ **State** _____ **Zip** _____

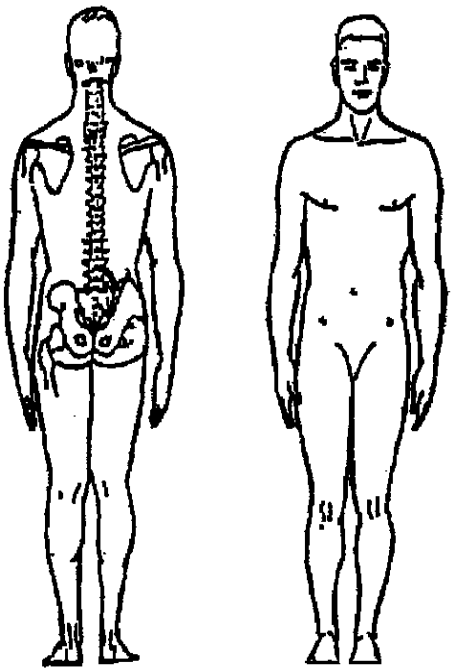
Insurance Company _____ **Your Social Security #** _____

Do you have Medicare? Yes ____ No ____ **Do you have Medicaid? Yes ____ No ____**

Name of Spouse or Parent _____ **His/Her Birthdate** _____

Spouse Employed By _____ **Occupation** _____**Years On Job** _____

Employer Address _____ **City** _____ **State** _____ **Zip** _____



Work Phone # _____ **Spouse's SS#** _____

Does your spouse have health insurance at work? Yes _____ No ____

COMPLETE THESE DIAGRAMS

If you are in pain, **please mark the exact location of your pain on the diagram**. Also describe the type and frequency of your pain, as well as any activity which brings on or aggravates the pain**. For example: dull, sharp, consistent, off & on, when standing, when sitting, etc.**

MAJOR COMPLAINTS

(Please list any condition you are being treated for or are experiencing.)

_____

_____

_____

_____

Is your condition due to an accident? Yes _____ No _____

Date of accident? _____ **Type of accident? Auto _____**

Work/On Job _____ At Home _____ Other _____

Have you been in an auto accident? Past Year ____ Past 5 Years ____ Over 5 Years ____ Never ____

REFERRED TO OUR OFFICE BY: _____

INFORMATION/APPLICATION FOR CARE

I (we) agree to pay for services rendered to the above mentioned patient as the charge is incurred. I understand and agree that health & accident insurance policies are an arrangement between an insurance carrier and myself and that I am personally responsible for payment of any and all services covered or not covered. I also understand that if I suspend or terminate my care and treatment, any fee for professional services rendered me will be immediately due and payable.

Patient's Signature _____ Date _____

Or Guardian Signature _____ Date _____

Notice to our new patients: Full payment for services rendered is due at the end of each visit. If for any reason this request cannot be met, arrangements should be made in advance before seeing the doctor.

Insurance cases: On all insurance assignments, the deductible should be met in the beginning unless prior arrangements are made.