PATIENT INFORMATION

Date ___________________

Please check the type of care desired: • Pain Relief only • Lasting Correction and Prevention

Name ___________________________________ Home Phone ____________ Cell Phone ______________

Address _________________________________ Apt# _______ City ___________________ State _______

Zip _________ Age _________ Birth Date ________________ Marital: M S W D

Social Security # __________________________ E-mail ____

Person to Contact in Case of an Emergency and Phone # ____

Occupation _________________________ Employer ____

Employer's Address ____ Work Phone _________________

Have you ever received Chiropractic Care? • Yes • No If so when? ___________________________

Date Symptoms Appeared ___________________

Check All the Symptoms You Have Noticed Relating to This Problem or Accident:

- Neck Pain
- Neck Stiff
- Pain between Shoulders
- Mid-back Pain
- Mid-back Stiff
- Low-back pain
- Low-back stiff
- Muscle Spasms
- Pain Down Arm(s)
- Pain Down Leg(s)
- Numb Finger(s)
- Numb Toe(s)
- Pins & Needles in Arm(s)
- Pins & Needles in Leg(s)
- Headache
- Dizziness
- Light Headed
- Head Feels Heavy
- Confusion
- Nervousness
- Fatigue
- Irritability
- Chest Pain
- Shortness of Breath
- Tension
- Depression
- Fainting
- Cold Sweats
- Disoriented
- Ringing in Ears
- Loss of Balance
- Blurred Vision
- Lights bother eyes
- Other :

Any Other Complaints and Symptoms? ____

____

____

Date of Last Physical Exam _________________________

What Surgeries Have You Had? (Include Dates) ____

Serious Illnesses (Include Dates) ____

Dislocations &/or Fractures (Include Dates) ____

Do You Currently Have Any Health Conditions or Serious Illnesses? • Yes • No If Yes, Describe:

____

____

What Medications or Drugs are You Taking? ____

Do You Have Any Allergies? ____

Do You Smoke? • Yes • No (Next Page)

Do You Have Health Insurance? • Yes • No

If Yes, Name of Primary Insurance Company ______________________________

Name of Secondary Insurance Company (If Any) ______________________________

If Related to an Auto Accident, Name of Your Auto Insurance Company ______________________________

Have You Filed a Claim With Your Auto Insurance Company, If so Claim # ______________________________

Name of Your Auto Agent or Claims Adjuster & Phone # ______________________________

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Do You Have Medical Coverage on Your Auto Insurance? • Yes • No

Attorney Name & Phone ______________________________

AUTHORIZATION AND RELEASE: I understand that it is this office's policy to collect charges as they are rendered unless other arrangements are made in advance.

I further understand that if the charges for services are covered by insurance, this office will bill my insurance company and agree to await payment and accept assignment of benefits for as long as the policy is in effect or until this office so chooses. I hereby authorize the payment of any insurance benefits to be paid directly to the chiropractor or chiropractic office. I UNDERSTAND AND AGREE THAT HEALTH AND AUTO ACCIDENT INSURANCE POLICIES ARE AN ARRANGEMENT BETWEEN MY INSURANCE CARRIER AND MYSELF AND THAT I AM RESPONSIBLE FOR ANY AND ALL CHARGES RENDERED ON MY BEHALF. This office will prepare any necessary reports or forms in order to assist me in making collections from the insurance company and that any amount authorized to be paid directly to this office will be credited to my account upon receipt. We will, however, not enter into a dispute with your insurance company over your claim. I also understand that if I suspend or terminate my care in this office, any unpaid balance for professional services rendered me will be immediately due and payable.

Please be advised that Meadows Chiropractic is the DBA (Doing Business As) for Mitchell Chiropractic Ltd, a professional corporation.

I permit this office to endorse any co-issued remittances for the conveyance of credit to my account.

If this account is assigned for collection and/or suit, collection costs and/or interest, and/or attorney fees, and/or court costs will be added to the total amount due.

Notice: Not all patients require x-rays to determine or verify a diagnosis, type of treatment and length of treatment; if your examination warrants x-ray analysis, the following office policy prevails: The fee paid for x-ray is for analysis only. The film itself is the property of this office.

Patient's Signature ______________________________ Date __________

Print Name ______________________________

Guardian's Signature Authorizing Care ______________________________ Date __________

Print Name ______________________________