



PERSONAL INFORMATION

First Name: _____ Last Name: _____ MI _____ Date: _____

Address: _____ City/State/Zip: _____

Home Phone: _____ Work Phone: _____

Mobile Phone: _____ Pager: _____ Email: _____

Social Security #: _____ Birth Date: _____ Age: _____ Sex: M F

Marital Status: S M D W Spouses Name: _____ # of Children: _____

Occupation: _____ Employer's Name: _____

Work Address: _____ City/State/Zip: _____

How were you referred to our office?:
Yellow Pages Drive By Newspaper TV
Friend _____ Other _____

Do you Have a Primary Care Physician? Yes No Name: _____ Phone #: _____

Address: _____ City/State/Zip: _____

Have you ever seen a Chiropractor Before? Yes No If Yes, When: _____

MAJOR COMPLAINT INFORMATION

What is/are your complaint(s)?: _____

When did these symptoms begin?: _____ Has this condition existed in the past?: Yes No

These symptoms were a result of: Auto Accident Work Injury Other _____

Is this condition getting progressively Worse? Yes No Constant Comes & Goes

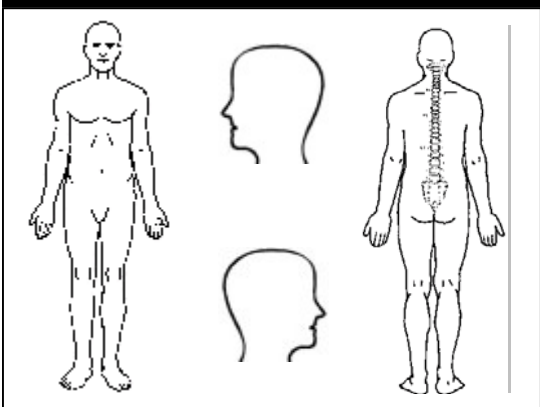
Is this condition interfering with your Work Sleep Daily Routine Other _____

How long has it been since you felt good?: _____

List other doctors who have treated this condition: _____

Have you been in an auto accident: Past year Past 5 years Over 5 years Never

Please Mark your areas of pain on the figures below:



If this is an injury, please describe what happened.

FINANCIAL RESPONSIBILITIES

I understand and agree that health and accident policies are an arrangement between an insurance carrier and myself. I authorize payment directly from my insurance company to Advanced Health Chiropractic. Furthermore, I understand that this office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to this office will be credited to my account upon receipt. However, I clearly understand and agree that all services rendered to me are ultimately my personal responsibility. I also understand that if I suspend or terminate my care and treatment any fees for professional service rendered me will be immediately due and payable.

If I have insurance, I am responsible for my insurance deductible, co-payments and any service rejected by my insurance company. I am also aware that if I have not made a payment on my outstanding balance within a 30 day period, a service fee of 2 % will be added to my account. If I have an outstanding balance that may be served to a collection agency, there will be an additional fifty dollar fee added.

This office cannot promise that an insurance company will pay. In the event that the insurance company disputes or rejects the claim, we will pursue on your behalf as far as we are able to. If unsuccessful, you will be expected to take responsibility for any outstanding balance.

I authorize this clinic to release any information pertinent to my case to any insurance company, adjuster and/or attorney involved in this case, and hereby release this clinic of any consequences thereof.

Although our office will call to verify your insurance coverage, it is your responsibility to confirm and know your benefits. If you have limited coverage, you need to be aware of when your insurance will stop paying your claims.

I certify that the information provided in this four-part form is correct to the best of my knowledge. I will not hold my doctor or any staff member of Advanced Health Chiropractic responsible for any errors or omissions that I may have made in the completion of this form

Signature of Patient: _____ Date: _____

Signature of Parent or Guardian: _____ Date: _____

ACKNOWLEDGEMENT AND UNDERSTANDING

I acknowledge and agree to the following:

The doctor will not be held responsible for any pre-existing medically diagnosed conditions.

Chiropractic is not a treatment for any condition or symptom. It is a care system that is aimed toward the reduction and correction of spinal subluxations so that your body as a whole may function better.

Although Chiropractic care is one of the safest forms of health care, it is associated with some minor risks and it is my responsibility to be informed about those risks by asking the doctor or a staff member prior to treatment.

Chiropractic is a system of health care delivery and therefore, as with any health care delivery system, we cannot promise a cure for any symptom, condition or disease as a result of treatment in this office. An attempt to provide you with the very best care is our goal and if the results are not acceptable, we will refer you to another health care professional who we feel can further assist you.

I hereby authorize the doctors and staff affiliated with Advanced Health Chiropractic to treat my condition as deemed appropriate.

Signature of Patient: _____ Date: _____

Signature of Parent or Guardian: _____ Date: _____

RECORDS RELEASE

To _____, I hereby authorize you to release to _____ any information including the diagnosis and records of treatment or examination rendered to me for all care during the period of _____ to _____.

Signature of Patient: _____ Date: _____

Signature of Staff: _____ Date: _____

CONSENT OF TREATMENT OF MINOR CHILD

I hereby authorize Dr. _____ and whomever he may designate as assistance to administer chiropractic care as he deems necessary to my _____ (indicate relationship to child).

Name of Child: _____ Date: _____

Signature of Parent or Guardian: _____

Signature of Staff: _____ Date: _____

CHECK THE FOLLOWING CONDITIONS AS THEY APPLY TO YOU

Never Previously Presently	Never Previously Presently	Never Previously Presently	Never Previously Presently
GENERAL SYMPTOMS/ CONDITIONS Migraines Allergy (what) _____ Bronchitis Chills (Constant) Convulsions Dizziness Fainting Fatigue Headache Loss of Sleep Loss of Weight Nervousness Night Sweats Numbness or Pain in arms/legs/hands Wheezing Polio Alcoholism Anemia Chicken Pox Rheumatic Fever Pleurisy Arthritis Mumps Cancer Tuberculosis Venereal Disease HIV Positive Diabetes Measles Serious Injury _____ other _____ other	GASTRO-INTESTINAL Belching or Gas Acid Reflux Heart Burn Colon Trouble Constipation Diarrhea Gall Bladder Trouble Hemorrhoids (piles) Jaundice Liver Trouble Nausea Stomach Pain Vomiting Vomiting Blood Bloody Stool Irritable Bowel Ulcers CARDIO-VASCULAR High Blood Pressure Strokes Low Blood Pressure Chest Pain Heart Trouble Poor Circulation Rapid Heart Slow Heart Swollen Ankles Varicose Veins Pacemaker	EYE/EAR/NOSE/THROAT Sinusitis Asthma Deafness Earache Ear Discharge Ear Noises Thyroid Problems Frequent Colds Hay Fever Nasal Obstruction Nose Bleeds Pain in Eyes Poor Vision Blurred Vision Sore Throats Tonsillitis MUSCLES & JOINTS Backache Pain Between Shoulders Stiff Neck Foot Trouble Hernia Painful Tail Bone Spinal Curvature Swollen Joints Tremors Twitching Spinal Disc Disease Dislocated Joints	RESPIRATORY Chronic Cough Difficulty Breathing Spitting Blood Spitting Phlegm GENTO-URINARY Bed Wetting Blood in Urine Frequent Urination Inability to Control Urine Kidney Infections Kidney Stones Painful Urination Prostate Trouble NEUROLOGICAL Anxiety Mood Swings Phobias Mental Disorders Multiple Sclerosis Epilepsy Memory Loss or Impairment Depression FOR FEMALES ONLY Irregular Cycle Cramps Hot Flashes Painful Periods Yes No Pregnant at this time? _____ Last Menstrual Cycle

ADDITIONAL INFORMATION

List all medications you are taking now, including over the counter medication: _____

Do you have, or have you ever had, any diseases or medical problems not listed? Yes No

If so, please list: _____

Any additional information you would like the doctor to know about before beginning care at Advanced Health Chiropractic Center? _____