

NEW PATIENT APPLICATION

Welcome to our Practice! Please thoroughly complete all questions. Thank you.

Name: _____ Today's Date: _____

Address: _____

City/State/Zip: _____ E-Mail: _____

Phone: Home: _____ Cell: _____ Work: _____

Marital Status: M/P/W/D/S

Birthdate: ___/___/___ Age: _____ Social Security #: _____

Whom may we thank for referring you? _____

Your prior Doctor of Chiropractic: _____
and address _____

Chiropractic techniques you've had success with: _____

Last time you went to previous Doctor of Chiropractic: _____

General Practitioner: _____ and City _____

Your Employer: _____ Phone Number () _____

Employer's Address: _____

Occupation: _____

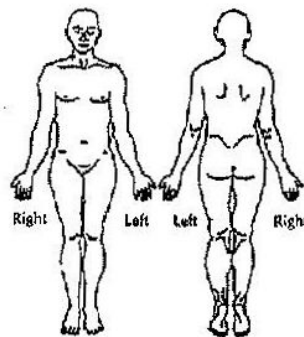
Spouse's Name: _____

Spouse's Employer: _____

Children's Name & Ages: _____

Favorite Hobbies or Interests: _____

Mark areas of Health Concerns



Health Reasons for Consulting Our Office:

1. _____ 3. _____
2. _____ 4. _____

Have you had the same or similar problem(s) before? Yes No

How Long?: _____ Please Explain: _____

Father/Mother/Brother/Sister/Children, with similar problems? _____

Is this the result of an auto or work injury? _____ If so, when? _____

If this is a work injury, is there a panel chiropractor that your company's Worker's
Compensation
Insurance requires you to see in the first 90 days? If so, please list their name.

Other Doctors who have treated this problem: _____

Surgery you have had: _____

Medication(s) you currently take: _____

Is there any chance you are pregnant? Yes _____ No _____

What have you heard about chiropractic? _____

Do you know what a subluxation is? _____ If yes, please describe _____

What daily rituals for spinal health do you presently practice? _____

Have you ever been diagnosed with cancer? _____ If so, what kind? _____

Do you have health insurance? _____ Name of Company: _____
I.D. # _____ Group # _____
Name of Insured _____

Method of Payment for First Visit: _____ Cash _____ Check _____ Credit Card

I understand and agree that health and accident policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that this Chiropractic 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 Chiropractic Office will be credited to my account on 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. If I fail to pay for services rendered and you are required to institute collection proceedings, I agree to pay for reasonable attorney's fees and costs in attempting to collect the balance. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered me will be immediately due and payable.

Patient's Signature _____ Date _____
Guardian or Spouse's Signature _____