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**

NAME(first mi last)____Today's Date_____________

Home # ________________Work #______________Cell #________________

Address______________________________ City__________________ State_____ Zip___________

Age__________ Birth date______________ Marital Status: S M W D No. of Children___________________

Email Address___________________________ May we email you? Yes _______No _______

Please circle one payment type: Cash Check Credit Card

Your Employer_______________________________ Occupation___________________ Years on Job______________

Employer Address_________________________________ City_________________ State_____ Zip__________

Your SS#________________________ Your Driver's License # ______________________________

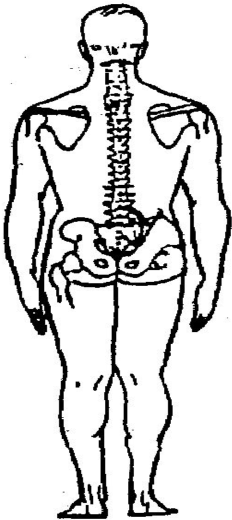
Do you have Medicare or Medicaid? Yes ______No_______

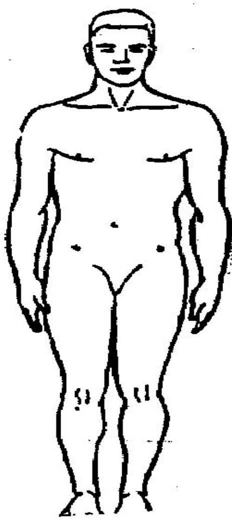
Name of Spouse or Parent _____________________________________ Birth date______________

Spouse employed by ____________________________________Occupation_________________ Years on Job________

Employer Address______________________________________City________________State______Zip________

Work phone_____________________ Spouse SS#____________________





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)

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Referred to our office by:______________________________

How payment will be made:

_______ Cash _______ Workmen's Comp. _______Check _______ Credit Card _______Auto Ins. Policy

Is your condition due to an accident? Yes_____ No_____ Date of Accident ______________________

Type of accident? Auto_____ Work/On Job______ At Home _______ Other __________________________

Have you ever been in an auto accident? Past Year______ Past 5 Years_____ Over 5 Years_______ Never_________

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

Patient's Signature____ Date_______________

Or Guardian Signature____ Date_______________