

ADVANTAGE WALK-IN CHIROPRACTIC

Confidential Patient Information

Name (first & last) _____ Date _____
Address _____ City _____ State _____ Zip _____
D.O.B. (mo/day/yr) ____/____/____ Age _____ Sex M/F Marital Status _____ Spouse _____
Social Security # _____ - _____ - _____ Home Phone # (____) _____ Cell # (____) _____
Employer _____ Address _____ Work # (____) _____
Spouse's Employer _____ Phone # (____) _____ Spouse SS # _____ - _____ - _____
E-Mail _____
Emergency Contact _____ Phone # (____) _____

Who referred you to our office? _____

Is your visit due to an accident? No Yes (if yes, please see receptionist for an injury report.)

Your Present Complaint _____

BRIEFLY DESCRIBE YOUR SYMPTOMS _____

List other doctor(s) seen for this condition _____

Medical History (if any of the following are relevant to your medical history, please check the accompanying box)

Cancer	Muscular Dystrophy	Rheumatic Fever	Digestive Disorders
Polio	Multiple Sclerosis	Scarlet Fever	Sinus Trouble
Tuberculosis	Convulsions	Nervousness	Backaches
High Blood Pressure	Epilepsy	Asthma	Numbness
Heart Trouble	Concussion	Dizziness	Arthritis
Diabetes	Hepatitis	German Measles	Venereal Disease

Describe any operations you've had (and dates): _____

Have you been treated by a physician for any health condition in the last year? No Yes
Describe condition: _____ Date of last physical exam _____

Are you now taking any medication? No Yes If so, what kind? _____

Are you allergic to any medication? No Yes If so, what kind? _____

Are you pregnant? Yes No Date of last menstrual period _____

Do you have insurance? Yes No Company _____
Policy Number _____ Group Number _____

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. 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. I permit this office to endorse co-issued remittances for the conveyance of credit to my account. 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. It is my understanding that my credit may be checked if Advantage Walk-In Chiropractic extends credit to me, and I also understand that if I suspend or terminate my care and treatment, and fees for professional services rendered to me will be immediately due and payable, unless prior arrangements are made. I understand that if my account is 60 days past due an \$5 late fee will be assessed per billing cycle and any accounts 120 days past due will be forwarded to our collections department and will be subject to collection-processing fees. If my check is dishonored I understand that a \$25 processing fee will be assessed to my account. I hereby authorize the doctors at Advantage Walk-In Chiropractic and whomever they may designate as their assistants to administer treatment as they so deem necessary and also authorize the release of any information acquired in the course of my examination or treatment. I certify that the above information is true and correct.

Patient's (Parent or Guardian's) Signature _____