

# PATIENT INTRODUCTION FORM

Today's Date: \_\_\_\_\_

2007 Update

<b>Last Name:</b>	<b>MI:</b>	<b>First Name:</b>	
Home Address:	City :	State:	Zip:
Date of Birth:	Age:	Home Telephone:	
E-mail Address:		Mobile Telephone:	
Employer:		Work Telephone:	
Occupation:		Social Security Number:	
Drivers License Number:		<b>Referred By:</b>	
Marital Status (circle): Single, Married, Divorced, Widowed		Name of Spouse:	

Name, Address, Relationship, and Telephone Number of your nearest adult relative (for emergencies):

Primary Physician Name and Telephone Number:
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## INSURANCE INFORMATION

<b>Does your insurance plan cover Chiropractic treatment?</b>	<input type="checkbox"/> Yes, <input type="checkbox"/> No If yes, we need a copy of the card
It is your responsibility as the patient to know and understand your medical benefits. Please note: The agreement of insurance is a contract between you and your insurance company. You are responsible for payment in full if for any reason payment is not made on a claim within 30 days of submission. <b>For Your Convenience we accept Cash, Checks and all major Credit Cards.</b>	Carrier Name:
	Address:
	Telephone:
	ID Number:
	Group Number:
<b>Are you the insured person or dependent (Spouse/Child)?</b>	<input type="checkbox"/> Insured, <input type="checkbox"/> Dependent
If you are the insured persons dependent (spouse/child), we need the insured persons name, date of birth, social security number, and the name of the insured employers business in order to do billing.	Name of Insured Person:
	Social Security Number:
	Insured Date of Birth:
	Name of Insured Employer:

<b>CHECK SYMPTOMS YOU HAVE NOTICED SINCE ACCIDENT OR ILLNESS:</b>				
<input type="checkbox"/> Headache	<input type="checkbox"/> Dizziness	<input type="checkbox"/> Lights Bother Eyes	<input type="checkbox"/> Diarrhea	<input type="checkbox"/> Tuberculosis
<input type="checkbox"/> Neck Pain	<input type="checkbox"/> Head Seems Heavy	<input type="checkbox"/> Loss of Memory	<input type="checkbox"/> Feet Cold	<input type="checkbox"/> Arthritis
<input type="checkbox"/> Neck Stiffness	<input type="checkbox"/> Pins & Needles in Arms	<input type="checkbox"/> Ears Ring	<input type="checkbox"/> Hands Cold	<input type="checkbox"/> Asthma
<input type="checkbox"/> Sleeping Problems	<input type="checkbox"/> Pins & Needles in Legs	<input type="checkbox"/> Face Flushed	<input type="checkbox"/> Stomach Upset	<input type="checkbox"/> Neuritis
<input type="checkbox"/> Back Pain	<input type="checkbox"/> Numbness in Fingers	<input type="checkbox"/> Buzzing in Ears	<input type="checkbox"/> Constipation	<input type="checkbox"/> Digestive Disorders
<input type="checkbox"/> Nervousness	<input type="checkbox"/> Numbness in Toes	<input type="checkbox"/> Loss of Balance	<input type="checkbox"/> Cold Sweats	<input type="checkbox"/> Sinus Trouble
<input type="checkbox"/> Tension	<input type="checkbox"/> Shortness of Breath	<input type="checkbox"/> Fainting	<input type="checkbox"/> Fever	<input type="checkbox"/> Anemia
<input type="checkbox"/> Irritability	<input type="checkbox"/> Fatigue	<input type="checkbox"/> Loss of Smell	<input type="checkbox"/> Heart Trouble	<input type="checkbox"/> Rheumatic Fever
<input type="checkbox"/> Chest Pain	<input type="checkbox"/> Depression	<input type="checkbox"/> Loss of Taste	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Cancer

Our office will provide insurance billing services for you if you so desire as a courtesy. *Remember that you are ultimately responsible for charges incurred in this office. It is your responsibility to pay any deductible amount, co-insurance, and/or any other balances not paid by your insurance carrier within 30 days of claim submission. All requests for copies of Medical Records or a Report will require a minimum \$35.00 payment from the patient to cover clerical and copy fees. You are also responsible for any treatment your Insurance company may deem not medically necessary.* \_\_\_\_\_ **initial**

IN ORDER TO KEEP OUR OFFICE OVERHEAD DOWN AND KEEP OUR PATIENT FEES REASONABLE, WE EXPECT PAYMENT AT THE CONCLUSION OF EACH TREATMENT. IF YOU ARE SEEN MORE THAN ONE TIME A WEEK YOU MAY SIGN A "PRE-AUTHORIZATION PAYMENT FORM" AND YOUR CREDIT CARD WILL BE CHARGED AT THE END OF EACH WEEK OF TREATMENT. 24-hour notice is required for cancellation or you will be charged a cancellation fee of \$35.00

**Your signature on this document indicates that you understand and agree with our Office Policies.**

I have read all the information on this sheet and have completed the above answers. I certify this information is true and correct to the best of my knowledge. I will notify you of any changes in my status of the above information.

Signature of responsible party (Patient or Parent): \_\_\_\_\_ Date: \_\_\_\_\_