Patient Application

Last Name _____ First _____ Middle In. _____ Date _____

Address _____ City _____ State _____ Zip _____

Home Phone (____)_____ Work Phone (____)_____ Cell Phone (____) _____

E-mail _____ Referred by: _____

Occupation _____ Employer _____ Hours per week worked _____

D.O.B. ____/____/_____ Age _____ Social Security # _____ ❑ Male ❑ Female ❑ Married ❑ Single

Emergency Contact _____ Ph.# _____ Relationship: _____

Family Doctor _____ Phone #_____ Last Exam Date _____

What is your main complaint(s)? _____

Is condition: □ Job related □ Auto Accident □ Home Injury □ Fall □ Unknown □ Other _____

Circle the INTENSITY of your PAIN when present (0=no pain, 10=severe pain): 0 - 1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10

Mark the FREQUENCY of your PAIN: □ Constant (75-100%) □ Frequent (50-75%) □ Occasional (25-50%) □ Intermittent (0-25%)

Describe the Pain (mark all that apply): □Dull, □Sharp, □Ache, □Throb, □Burning, □Numb, □Tingling, □Cramping, □Spasm, □Shooting

Other Conditions in past 6 weeks: □ Headaches, □ Neck Pain, □ Shoulder pain (R - L), □ Pain between shoulders, □ Low back pain, □ Buttock Pain (R - L), □ Hip Joint Pain (R - L), □ Arm/hand numb/tingle (R - L), □ Leg/foot numb/tingle (R - L)

Insurance: Complete only if patient is not the primary insured policyholder

Insured's name:_____ Insured's date of birth_____ Insured's SS#_____

Financial Release and Assignment:
Payment is expected on the date that services are rendered. Insurance filing is a courtesy for our patients. Balance for services is the patient responsibility. I understand any outstanding accounts beyond 90 days may result in a 25% finance charge per month. If the account is sent to collections, any fees associated with the collection of charges will also be billed to the patient (according to Collection Agency fee amounts). I authorize the release of any information necessary to process my insurance claims and request payment be sent directly to my physicians.

X-ray Consent:
The purpose of the x-ray examination to be performed is to analyze the spine for evidence of vertebral subluxation, rate and level of degeneration of the spine, and to determine the appropriate care. If the doctor discovers an "unusual finding" when reviewing the x-rays, I will be informed. With the help of the doctor, I thus must determine if I should seek the services of an additional healthcare provider for advice, diagnosis, or treatment of the unusual finding. I fully understand the above and consent to spinal x-rays.
WOMEN ONLY - Pregnancy Release: This is to certify that to the best of my ability I am not pregnant and I give my permission to perform an x-ray evaluation. I understand the risks of an x-ray to an unborn child. Date of last menstrual period: _____

Consent to Receive Care:
I, the undersigned, give this office (doctors and/or practitioners) permission and authority to provide care in accordance with standard diagnosis and treatment. The office will not provide care, without consent of the patient, if they are aware of any contraindication that my be present. It is the responsibility of the patient to discuss with the office any known underlying deformities or defects that may not otherwise come to the attention of the office. I do not expect the office to be able to anticipate and explain all risks and complications and I wish to rely on the office to exercise judgment during the course of the procedure which the office feels at the time, based upon the facts then known, is in my best interests.

HIPAA Privacy Rule: This office is required by law to maintain the privacy and confidentiality of your protected health information. By signing this form, I release this office from all liability and give permission to use my first and last name for the purpose of speaking with me in the presence of others. I understand that I may request a detailed copy of the HIPAA privacy rule at any time.

I have read and fully understand the above statements and accept care on this basis.

Patient/Parent/Advocate Signature: _____ Date: _____