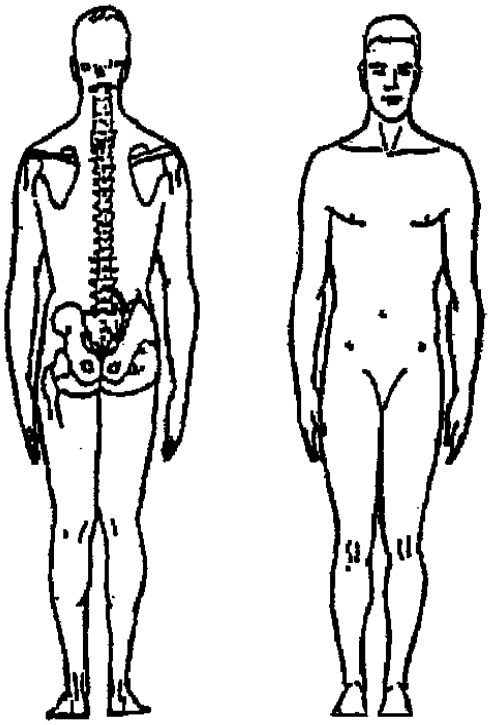
INFORMATION/APPLICATION FOR CARE

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.) Today's Date_____

Full Legal Name _____
Home Phone _____ Work Phone _____Cell Phone _____
E-Mail Address _____
Address _____ City _____ State _____ Zip _____
Age _____ Birth date _____ Marital Status: S M W D Your Social Security # _____
Your Employer _____ Occupation _____
Employer Address _____ City _____ State _____ Zip _____
Insurance Company _____ 2nd Insurance Company _____
Name of Spouse or Parent _____ Their Birth date _____
Spouse Employed By _____ Occupation _____
Employer Address _____ City _____ State _____ Zip _____



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.)

_____
_____
_____
_____
_____
Referred to our office by: _____

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

Patient's Signature _____ Date _____

Or Guardian Signature _____ Date _____