Today's Date_____

Patient Information

First Name _____M.I.____ Last Name_____
Date of Birth: _____ Social Security Number_____-_____-_____ Sex: Male / Female
Address: _____City: _____ State: _____ Zip_____
Marital Status: Married, Single, Divorced, Widowed Home Phone#(_____)_____-_____
How did you hear about us: _____ Cell Phone # (_____)_____-_____
E-mail:_____ Work Phone #(_____)_____-_____

Please choose one of the following:

I want to pay out of pocket for services rendered and bill my insurance company myself (and receive a Time of Service discount)

OR

I want my insurance company billed and I will pay my co pay, deductible, etc. on each visit.

Insurance Information

Insured (If other than you)
First Name_____ M.I._____ Last Name_____
Sex_____ D.O.B._____ Social Security Number_____-____-_____
Address_____ City _____State _____
Zip _____ Phone (___) ____-_____

Primary Insurance
Insurance Carrier _____Group #_____ ID #_____
Address_____City_____State_____ Zip_____
Phone (___) ____-_____

Secondary Insurance
Insurance Carrier _____ Group #_____ ID#_____
Address_____City_____State_____ Zip_____
Phone (___) ____-_____

Employer
Current Employer_____Occupation_____
Address_____City_____State_____ Zip_____
Phone (___) ____-_____

Onset (Injury)

Is this injury a:
____ Auto Accident OR ____ Work Comp Injury

Date of Injury _____/_____/_____
Time of Injury _____:_____ ____am ____pm
Date of 1st Tx _____/_____/_____

Emergency Contact

Name: _____Relation:_____
Home/Cell Phone # (_____) _____-_____ Work Phone # (_____) _____-_____

Health History

Are you taking any of the following medications?

Nerve Pills Pain Killers (including aspirin) Muscle Relaxers Stimulants Blood Thinners Tranquilizers Insulin Other(s) _____

Have you ever had any of the following diseases/medical condition?

Y N Heart Attack/Stroke
Y N Congenital Heart Defect
Y N Alcohol/Drug Abuse
Y N HIV+ / AIDS
Y N Frequent Neck Pains
Y N High/Low Blood Pressure
Y N Severe/Frequent Headaches
Y N Fainting/Seizures/ Epilepsy
Y N Diabetes/ Tuberculosis

Y N Lower Back Pains
Y N Heart Surgery /Pacemaker
Y N Mitral Valve Prolapsed
Y N Shingles
Y N Emphysema/ Glaucoma
Y N Psychiatric Problems
Y N Sinus Problems
Y N Difficulty Breathing
Y N Artificial Bones/ Joints
Y N Heart Murmur

Y N Artificial Valves
Y N Hepatitis
Y N Cancer
Y N Anemia
Y N Rheumatic Fever
Y N Ulcers/Colitis
Y N Asthma
Y N Chemotherapy
Y N Arthritis

Please list any other serious condition(s) you have ever had: _____
_____
_____

Please List anything that you may be allergic to:_____
_____

List previous surgeries/treatment with dates: _____
_____

List any past serious accidents with dates: _____
_____

For Women: Are you taking Birth Control? Yes No

Are you pregnant? No Yes/How long?_____ Nursing? Yes No

Release Information

I hereby authorize STRESS RELIEF CHIROPRACTIC CENTER to release medical and financial data to my insurance carriers and attorney **INITIALS** _____

Responsibility of the Bill

The undersigned hereby accepts full financial responsibility for charges and services rendered to the patient. The undersigned understands that services are rendered and charged to the patient and not to the insurance company. STRESS RELIEF CHIROPRACTIC CENTER cannot accept total responsibility to collecting an insurance claim or negotiating a dispute settlement. The undersigned also agrees that this obligation shall exist regardless of private contractual agreement between the patient and any insurance carrier, attorney, or third party not signing this agreement. Financial responsibility will also include charges and services not covered by insurance for which payment is denied through any utilization review or precertification procedures. **INITIALS**_____

AUTHORIZATION FOR PAYMENT OF INSURANCE BENEFITS TO PROVIDER

I hereby irrevocably authorize payment of the medical benefits otherwise payable to me to be made payable and mailed directly to STRESS RELIEF CHIROPRACTIC CENTER for professional services rendered. NO OTHER THIRD PARTY, including my attorney, should receive payment of my bills except if this office for that remainder of this claim. It will be assumed and relied upon that the insurance carrier has agreed to and acknowledges medical coverage and will send payment directly.

INITIALS_____

I understand that the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes in my medical status.

SIGNATURE_____ **DATE**_____

If signing for a minor, please write your name and the relation to the minor.

NAME _____ **RELATION** _____