OFFICE USE

F/C: ☐ INS ☐ SP ☐UC ☐ WC ☐ AA ☐ PI ☐ MC ☐ CAP PFC#: _____

Included: ☐ Insurance Card Copy ☐Purple Letter ☐Employer Claim Form ☐Referral

Thank you for choosing Pins Family Chiropractic Clinic. In order to help us complete records and submit accurate bills to your insurance company, please assist us by providing the following information.

1 PATIENT INFORMATION

Date_____ Patient's Social Sec. #: _____-_____-_____ Date of Birth _____

First Name _____ Middle Initial _____ Last Name _____

Mailing Address _____

City _____ State _____ Zip Code _____

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

Email _____ Employer _____ Occupation _____

In case of emergency contact Name_____ Relationship _____

Home (_____) _____Work (_____) _____

☐ Male ☐ Female ☐Single ☐Married ☐Widowed ☐Separated ☐Divorced Are you pregnant ☐Yes ☐No

Who were you referred by: _____

Please complete the following section and present your Insurance Cards

2 INSURANCE INFORMATION

	PRIMARY INSURANCE	SECONDARY INSURANCE
Relation to Insured	☐ Self ☐ Spouse ☐ Child ☐ Other	☐ Self ☐ Spouse ☐ Child ☐ Other
Complete the following Insured information if *RELATION* is other than *SELF*		
Insured's Name:		
Insured's Birthdate:		
Male or Female:		
Complete the following Insured information if it differs from the Patient's		
Insured's Address:		
City, State, Zip:		
Phone Number:	( )	( )

3 ACCIDENT INFORMATION (If patient condition is due to an accident/injury)

CLAIM FILING INFORMATION	
Accident type:	☐ Auto Accident ☐ Other Personal Injury ☐ Work Related
Date of injury/accident:	
Insurance Carrier Name:	
Carrier address:	
City, State, Zip	
Adjuster's name:	
Adjuster's Phone Number:	( )
Claim Number:	

I, the undersigned, hereby authorize the staff to perform such services as deemed necessary by the chiropractic physician to diagnose and treat my condition(s). Further I authorize assignment of my Insurance rights and benefits directly to this provider and also authorize the release of such information as is needed to process Insurance claims by provider or agent. I understand that I am responsible for all charges which may include legal fee, collection fees or other expenses incurred by the provider in collecting my account. Additionally, I authorize this office to release any and all of my medical records as deemed necessary. I hereby order all parties to accept a copy of this release and assignment in lieu of the original. This shall remain in effect until revoked by me in writing.

4 PERSONAL HEALTH HISTORY

What treatment have you already received for your condition? ☐Medications ☐Surgery ☐Physical Therapy ☐Chiropractic Care ☐None ☐Other_____

Family Medical Physician (Name, Address, Phone) _____

Place a mark only "Yes" to indicate if you have had any of the following:

AIDS/HIV	☐Yes ☐No	Ear Infections	☐Yes ☐No	Irregular Bowel Movements	☐Yes ☐No	Vaccinations	☐Yes ☐No
Alcoholism	☐Yes ☐No	Emphysema	☐Yes ☐No	Kidney Problems	☐Yes ☐No	Sciatica	☐Yes ☐No
Allergy Shots	☐Yes ☐No	Epilepsy	☐Yes ☐No	Liver Problems	☐Yes ☐No	Scarlet Fever	☐Yes ☐No
Anemia	☐Yes ☐No	Fractures	☐Yes ☐No	Measles	☐Yes ☐No	Stomach Ulcers	☐Yes ☐No
Appendicitis	☐Yes ☐No	Glaucoma	☐Yes ☐No	Mononucleosis	☐Yes ☐No	Stroke	☐Yes ☐No
Arthritis	☐Yes ☐No	Goiter	☐Yes ☐No	Multiple Sclerosis	☐Yes ☐No	Thyroid Problems	☐Yes ☐No
Asthma	☐Yes ☐No	Gout	☐Yes ☐No	Mumps	☐Yes ☐No	Recurring Colds	☐Yes ☐No
Breast Lump	☐Yes ☐No	Headaches	☐Yes ☐No	Osteoporosis	☐Yes ☐No	Recurring Flues	☐Yes ☐No
Bronchitis	☐Yes ☐No	Heart Disease	☐Yes ☐No	Pacemaker	☐Yes ☐No	Recurring Strep/ Sore Throats	☐Yes ☐No
Cancer	☐Yes ☐No	Hepatitis	☐Yes ☐No	Parkinson's Disease	☐Yes ☐No	Rheumatoid Arthritis	☐Yes ☐No
Cataracts	☐Yes ☐No	Hernia	☐Yes ☐No	Pinched Nerve	☐Yes ☐No	Rheumatic Fever	☐Yes ☐No
Chemical Dependency	☐Yes ☐No	Herniated Disk	☐Yes ☐No	Pneumonia	☐Yes ☐No	Tonsillitis	☐Yes ☐No
Chicken Pox	☐Yes ☐No	High Cholesterol	☐Yes ☐No	Polio	☐Yes ☐No	Tuberculosis	☐Yes ☐No
Depression	☐Yes ☐No	High Blood Pressure	☐Yes ☐No	Prostate Problem	☐Yes ☐No	Tumors, Growths	☐Yes ☐No
Diabetes	☐Yes ☐No	Impotence	☐Yes ☐No	Prosthesis	☐Yes ☐No	Typhoid Fever	☐Yes ☐No
Digestive Problems	☐Yes ☐No	Infertility	☐Yes ☐No	Psychiatric Care	☐Yes ☐No	Whooping Cough	☐Yes ☐No

5 CHILDREN'S HEALTH HISTORY

Number of children?_____ Please check all that apply to any child.

Birth		ADD	☐Yes ☐No	Digestive Problems	☐Yes ☐No	Recurring Colds	☐Yes ☐No
Breech	☐Yes ☐No	Allergies	☐Yes ☐No	Ear Infections	☐Yes ☐No	Recurring Flues	☐Yes ☐No
C-section	☐Yes ☐No	Appendicitis	☐Yes ☐No	Headaches	☐Yes ☐No	Recurring Strep/ Sore Throats	☐Yes ☐No
Forceps	☐Yes ☐No	Asthma	☐Yes ☐No	Juvenile Arthritis	☐Yes ☐No	Seizures	☐Yes ☐No
Natural	☐Yes ☐No	Bed Wetting	☐Yes ☐No	Measles	☐Yes ☐No	Stomach Ulcers	☐Yes ☐No
Suction Cup	☐Yes ☐No	Bowel Problems	☐Yes ☐No	Mumps	☐Yes ☐No	Tonsillitis	☐Yes ☐No
Other_____		Chicken Pox	☐Yes ☐No	Pneumonia	☐Yes ☐No	Vaccinations	☐Yes ☐No
		Colic	☐Yes ☐No				

WORK ACTIVITY
☐Sitting ☐Standing ☐Light Labor ☐Heavy Labor

EXERCISE
☐None ☐Moderate ☐Daily ☐Heavy

HABITS
☐Smoking Packs/Day_____
☐Alcohol Drinks/Week_____
☐Coffee/Caffeine Drinks Cups/Day_____

Injuries/Surgeries you have had	Description	Date
Falls, Broken bones, head injuries		
Other		
Surgeries (Please include cosmetic/implants)		

Medications, Vitamins, Herbs currently taking _____

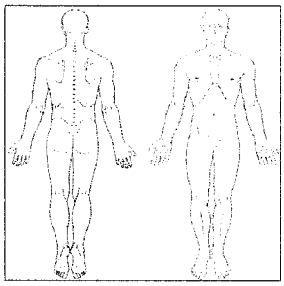
6 PATIENT CONDITION

Today's health complaint: _____

When did your symptoms appear?_____

Is this condition getting progressively worse? ☐Yes ☐No ☐Same

Mark an X on the picture where you continue to have pain, numbness, or tingling.



Rate the severity of your pain on a scale from 1 (least pain) to 10 (severe pain)_____

Type of pain: ☐Sharp ☐Dull ☐Throbbing ☐Numbness ☐Aching ☐Shooting ☐Burning ☐Tingling ☐Cramps ☐Stiffness ☐Swelling ☐Other

Have you seen a chiropractor before?_____ When ?_____Name _____

How often is this pain present? ☐Occasional 0-25% ☐Intermediate 26-50% ☐Frequent 51-75% ☐Constant 76-100%

Does it interfere with your ☐Work ☐Sleep ☐Daily Routine ☐Recreation