

HEALTH INFORMATION (continued):

Is your visit condition due to an AUTO or WORK Accident? Y / N (please ask to fill out Person Injury Form and Release)

Date of Accident _____ Claim # _____

If NOT Auto or Work, where did the injury occur? _____

HEALTH HISTORY:

Have you had previous Chiropractic Care? Y / N Date of last visit (00/00/0000) ____ / ____ / ____

Condition treated _____

Please list any health conditions that you have been treated for in the last year: (condition, cause, current/resolved) _____

Have you ever broken any bones? Y / N Please list _____

Have you had any surgeries? Y / N Please list _____

Have you had any cancer? Y / N Please list place and type _____

Has anyone in your family had cancer? Y / N Please list _____

Are you facing neurological conditions? Y / N Please list _____

Are you pregnant? Y / N Due Date _____

Smoking Status (please circle): Current Every day Smoker Current Some Day Smoker Ex-Smoker Never Smoked

Have you had any of the following medical conditions?

Gastro Intestinal Y / N Please list _____

Heart or Lung Disease Y / N Please list _____

Diabetes Y / N Please list _____

Eyes or Ears Y / N Please list _____

Nose or Throat Y / N Please list _____

Vascular Y / N Please list _____

PRIVACY PRACTICE ACKNOWLEDGEMENT

I have received the Notice of Privacy Practices and I have been provided an opportunity to review it.

Print Name Signature (If under 18, then Guardian Signature) Date

I certify that I'm the patient or legal guardian listed above. I have read/understand the included information and certify it to be true and accurate to the best of my knowledge. I consent to the collection and use of the above information to this office of chiropractic. I authorize this office and its staff to examine and treat my condition as the doctors see fit. I hereby authorize the doctor to release all information necessary to any insurance company, attorney, or adjuster for the purpose of claim reimbursement of charges incurred by me. I grant the use of my signed statement of authorization with my signature for required insurance submissions. I understand and agree that health and accident insurance policies are an agreement between an insurance carrier and myself. Furthermore, I understand that the office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to the office will be credited to my account on receipt. However, I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate treatment of my care, any fees for professional services rendered will be due within 30 days.

All missed office visits without notification will be billed to me at a rate of \$20.00 per visit.

Signature (If under 18, then Guardian Signature) Date



Chiropractic, Acupuncture and Massage

www.perfchiro.com

Shane Bates, DC, CCSP, ART

Larry Burrell, DC, ART

Michael Murphy, BHK, DC, ART

NEW PATIENT INFORMATION

To which doctor were you referred? (circle one) MURPHY BATES BURRELL PENNELL

PATIENT INFORMATION:

First Name _____ Middle Initial _____ Last _____ Mr. Mrs. Ms. Miss Dr. _____

Address _____ City _____ State _____ Zip _____

Birthdate (00/00/0000) _____ Marital Status _____ S M D W _____

Emergency Contact _____ Relationship _____ Phone Number _____

CONTACT INFORMATION:

Please circle THE PRIMARY NUMBER for us to contact and leave a message containing your appointment date and times.

Cell _____ Home _____ Work _____

Email _____

INSURANCE INFORMATION: PROVIDE US WITH YOUR INSURANCE CARD OR EMAIL FRONT AND BACK TO: info@perfchiro.com

This will be the insurance information in your file unless you notify us of any change. It is your responsibility to keep us updated prior to your appointment. Incorrect insurance information may result in no coverage and can mean additional out of pocket cost to you. INITIAL: _____

Please complete with Insured's Information if insurance is through someone other than you.

Name of Insured: First _____ Middle Initial _____ Last _____

Address _____ City _____ State _____ Zip _____

Birthdate (00/00/0000) _____ Relationship to Insured _____

Relationship to Insured _____

HOW DID YOU FIND OUT ABOUT OUR OFFICE?

Please circle one: Physician Patient Other (please specify) -- Name _____

HEALTH INFORMATION:

What is the purpose of your visit? _____

Other doctors seen for this condition? _____

Primary Doctor and Phone number _____

I AUTHORIZE this office to contact my Primary Physician regarding treatment in this office.

Signature (If under 18, then Guardian Signature) _____

Official team chiropractors for:
(Continued on back)

