NEW PATIENT INFORMATION

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

PATIENT INFORMATION:

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

Address | City | State | Zip

/ /

Birthday (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

/ /

Birthday (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)

(Continued on back)

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) ________

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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.

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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 $50.00 per visit.

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Signature (If under 18, then Guardian Signature) Date