

INFORMATION / APPLICATION FOR CARE

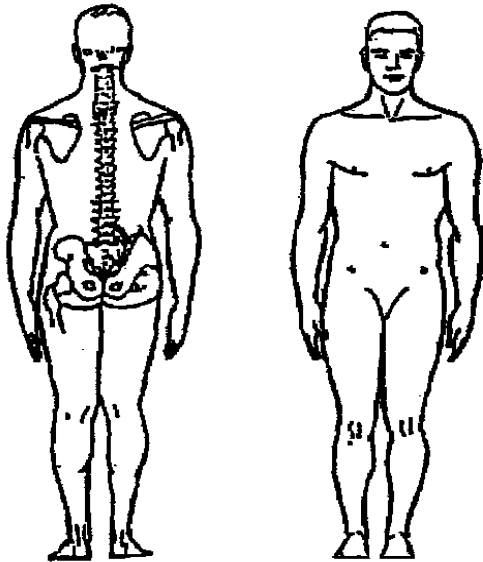
*The following information is needed in order to better serve you. Please complete all questions
 If you need help please ask the receptionist. (PLEASE PRINT.)*

Name _____ Home Phone _____ Work Phone _____
 Cell Phone _____ E-Mail Address _____
 Address _____ City _____ State _____ Zip _____
 Age _____ Birth date _____ Marital Status: S M W D Number of Children _____

Please **circle** one payment type: Cash Check Master Card/Visa American Express
 Your Employer _____ Occupation _____ Years On Job _____
 Employer Address _____ City _____ State _____ Zip _____
 Insurance Company _____ Your Social Security # _____
 Do you have Medicare? Yes _____ No _____ Do you have Medicaid? Yes _____ No _____
 Name of Spouse or Parent _____ Their Birthdate _____
 Spouse Employed By _____ Occupation _____ Years On Job _____
 Employer Address _____ City _____ State _____ Zip _____
 Office Phone # _____ Spouse's SS# _____ Driver's License # _____
 Does your spouse have health insurance at work? Yes _____ No _____

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: _____

How payment will be made: _____ Type of Insurance: _____
 _____ Cash _____ Worker's Comp. _____ Health Insurance
 _____ Check _____ Credit Card _____ Automobile Insurance Policy

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 _____