PATIENT INFORMATION

Please fill out as completely as possible.

PATIENT'S FULL NAME _____

DATE _____REFERED BY _____

ADDRESS _____

CITY _____ STATE _____ ZIP CODE _____

PHONE: HOME _____ CELL _____ WORK _____

AGE _____ BIRTH DATE _____ SEX _____ SS# _____

EMPLOYER_____

INSURANCE POLICY HOLDER NAME_____

INSURANCE POLICY HOLDER BIRTHDATE_____

SPOUSE'S OR PARENT'S FULL NAME _____

SPOUSE'S OR PARENT'S PHONE NUMBER _____

SPOUSE'S OR PARENT'S EMPLOYER _____

******PLEASE PROVIDE A COPY OF YOUR INSURANCE CARD OR CARDS. ALSO NEEDED IS INFORMATION ON INSURANCE HOLDER (FULL NAME, ADDRESS, BIRTHDATE, ETC.) ******

The fact that we will file your insurance claim and allow you to assign us benefits under your insurance policy does not relieve you from responsibility for any charges incurred. If your insurance company or other provider or source does not pay your claim, you will be responsible for all charges you incur.

I understand and agree that CHIROPRACTIC ARTS will assess no interest charges to my account for as long as I am current with any payments due. In the event that I fail to make timely payments as agreed, CHIROPRACTIC ARTS may, at their sole discretion, declare the entire balance to be due and payable. Further, I agree that if I am in default, interest may be charged to my account at the highest lawful rate, and I will be responsible for all costs of collection including court costs and a reasonable attorney's fee. In the event that this account is turned over for collection I hereby waive any and all right to exemption to which I may be entitled under the laws of the State of Alabama or any federal laws.

PATIENT'S SIGNATURE _____

PARENT'S OR GUARDIAN'S SIGNATURE _____

PATIENT MEDICAL HISTORY

NAME _____

Major complaints and/or symptoms _____
_____
If caused by accident, please describe:_____
_____
When did you first notice this? _____
Has this happened before? _____ When? _____
Is there any family history of this condition? _____ Who/What?_____
_____
Please list previous fractures, dislocations, spinal injuries, surgeries, or other serious illnesses._____
Are you presently being treated by any other physician, for any other condition? _____
What physicians, for what illnesses? _____
Please list all medications: _____
_____
Do you have or have you ever had a problem with any of the following symptoms or conditions?
Headaches _____ Rheumatic Fever _____ High Blood Pressure_____
Fatigue _____ Thyroid Problems _____ Low Blood Pressure _____
Dizziness _____ Sinus Problems _____ Ankle Swelling _____
Nervousness _____ Weight Gain _____ Fibromyalgia _____
Depression _____Constipation _____ Digestive Disorders _____
Weight Loss _____ Painful Urination _____ Arthritis _____
Chest Pains _____ Palpitations _____ Heart Attack _____
Stroke _____ Bursitis _____ Anemia _____
Asthma _____ Allergies _____ Hot Flashes _____
Back Pain _____ Neck Pain _____ Pelvis Pain _____
Numbness or Pain in arms, hands or legs? Please describe: _____
_____
Have you ever been exposed to the AIDS/HIV virus? _____
FEMALES: If you are pregnant, or think you are pregnant, please indicate here:_____
Date of last menstrual period: _____

I have read the above information and certify it to be true and correct to the best of my knowledge. I hereby authorize the office of CHIROPRACTIC ARTS to do whatever is necessary in accordance with Alabama Statutes, for the care and management of my condition.

Patient's/Guardian Signature: _____
Date: _____