



PERSONAL & INSURANCE INFORMATION

Name _____ Birthday _____ Age: _____ Sex: M F
 Address _____ Health Insurance Company _____
 City / State _____ Zip _____ Insurance Policy ID # _____
 Cell Phone # _____ Insured Person's Name _____
 Home Phone # _____ Insured Person's Birthdate _____
 Business Employer _____ Name & Number of Emergency Contact _____
 Business Phone # _____ Referred to This Office By _____
 Spouse's Name _____ Person Responsible for Bill _____
 Spouse's Employer _____ Circle One: Married Single Widowed Divorced Separated

CURRENT HEALTH CONDITION

Unwanted Health Condition or Chief Compliant: _____
 Other Doctors Seen For This Condition: Yes No Who? _____
 Type Of Treatment: _____ Results: _____
 When Did This Condition Begin? _____ Has This Condition Occurred Before? Yes No
 Is Condition: Job Related Auto Accident Home Injury Fall Other: _____
 Date Of Accident _____ Time Of Accident _____
 Have You Made a Report Of Your Accident To Your Employer Yes No
 Drugs You Now Take / Circle One: Nerve Pills Pain Killers/Muscle Relaxers Blood Pressure Medication Insulin
 Other Medications: _____
 Do You Wear A Shoe Lift? Yes No
 Do You Suffer From Any Condition Other Than That Which You Are Now Consulting Us? _____

CONSENT TO TREAT & BILL INSURANCE

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Further more, I understand that the Doctor's 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 Doctor's Office will be credited to my account on receipt. However, I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate, any fees for professional services rendered me will be immediately due and payable.

I hereby authorize the Doctor to treat my condition as he or she deems appropriate. It is understood and agreed the amount paid the Doctor, for x-rays, is for examination only and the x-ray negatives will remain the property of this office, being on file where they may be seen at any time while a patient of this office. The patient also agrees that he/she is responsible for all bills incurred at this office.

Patient's Signature _____ Date _____
 Consent To Treat A Minor _____ Date _____
 Guardian or Spouse's
 Signature of Authorizing Care _____ Date _____