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.)

Today's Date ______________

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 ____

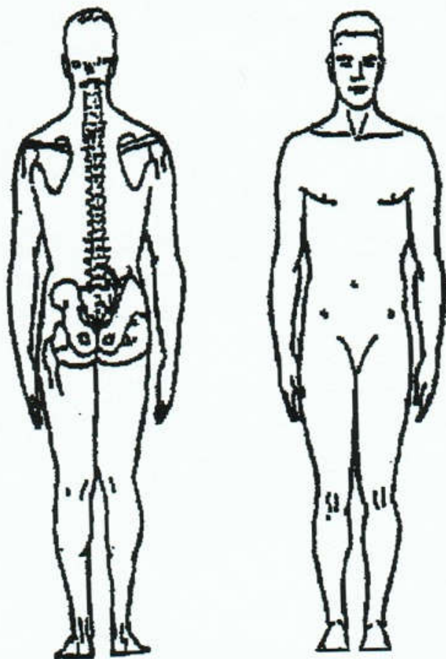
Name of Spouse or Parent __________________________________ Their Birthdate ______________

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:

__________ Cash

__________ Check

__________ Worker's Comp.

__________ Credit Card

Type of Insurance: ____________________________

__________ Health Insurance

__________ 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 ____