



## Welcome To Our Office!

(PLEASE PRINT)

Date \_\_\_\_\_

Name \_\_\_\_\_ Address \_\_\_\_\_

City, State, Zip \_\_\_\_\_ Contact Number \_\_\_\_\_

Email \_\_\_\_\_

Social Security # \_\_\_\_\_ Birthday \_\_\_\_\_ Age \_\_\_\_\_ Height \_\_\_\_\_ Weight \_\_\_\_\_

No. of Children \_\_\_\_\_ Marital Status - M S D W Spouse's Name or Parent \_\_\_\_\_

Your Occupation \_\_\_\_\_ Employed By \_\_\_\_\_ Work Phone # \_\_\_\_\_

Address \_\_\_\_\_ City, State, Zip \_\_\_\_\_

Who may we thank for referring you to our office? \_\_\_\_\_

Have you ever had Chiropractic Care before? \_\_\_\_\_ If so, when? \_\_\_\_\_

List your chief complaints in order of severity:

(1) \_\_\_\_\_ For how long? \_\_\_\_\_

(2) \_\_\_\_\_ For how long? \_\_\_\_\_

(3) \_\_\_\_\_ For how long? \_\_\_\_\_

List other doctors consulted for these conditions:

(1) \_\_\_\_\_ Address \_\_\_\_\_

(2) \_\_\_\_\_ Address \_\_\_\_\_

Is this injury or illness work-related? \_\_\_\_\_ Have you reported it to your employer? \_\_\_\_\_

Is this injury or illness related to an automobile accident? \_\_\_\_\_ (if yes, name of:)

Your Auto Ins. Co. \_\_\_\_\_ Policy # \_\_\_\_\_ Claim # \_\_\_\_\_

Address \_\_\_\_\_ Agent's Name \_\_\_\_\_

**NOTICE: Not all patients require X-rays to determine or verify a diagnosis, type of treatment or length of treatment; if your examination warrants X-ray analysis the following office policy prevails:**

**(1) All first visit charges without X-rays are payable when service is rendered.**

**(2) You will be referred out to get an X-rays if X-rays are warranted.**

Method of payment you plan to use to take care of today's charges:

Check  Cash  Mastercard  Visa  Discover

Major Medical Insurance Co. \_\_\_\_\_

Group Number \_\_\_\_\_ I.D. Number \_\_\_\_\_

Any Other Health Insurance Co. \_\_\_\_\_

Group Number \_\_\_\_\_ I.D. Number \_\_\_\_\_

Medicare \_\_\_\_\_ Medicare Number \_\_\_\_\_

**Surgery (Please include all surgery)**

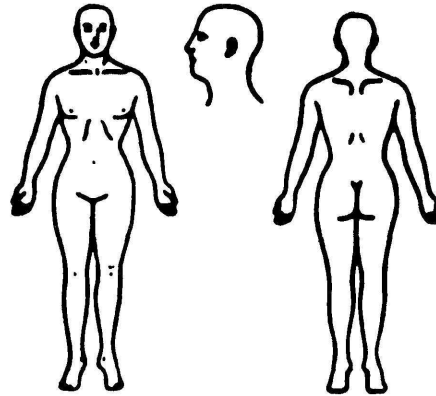
(1) Type \_\_\_\_\_  
(2) Type \_\_\_\_\_  
(3) Type \_\_\_\_\_

When \_\_\_\_\_  
When \_\_\_\_\_  
When \_\_\_\_\_

ARE YOU NOW OR HAVE YOU SUFFERED FROM ANY OF THE FOLLOWING:

Please mark your areas of pain on the figures below.

- Stroke
- Fatigue
- Migraine
- Nervousness
- Arthritis
- Numbness or pain in arms/legs/hands
- Pregnant at this time
- Pain between shoulders
- Spinal curvature
- Heart disease
- High blood pressure
- Headache
- Shingles
- Dizziness
- Heart attack
- Cancer
- Diabetes
- Sinus
- Stiff neck
- Backache
- Swollen joints



0 \_\_\_\_\_ 5 \_\_\_\_\_ 10 \_\_\_\_\_

Please rate your pain: 0 (No pain) to 10(Excruciating)

Are symptoms

- Getting worse
- Getting better
- Staying the same

**X-RAY CONFIRMATION:** This is to confirm that I have been advised by this office that x-rays can be hazardous to an unborn child. At this time, to the best of my knowledge, I am not pregnant, and I consent to spinographic pictures.

Signature \_\_\_\_\_ (Parent/Legal Guardian) Date \_\_\_\_\_

**CONSENT TO TREAT A MINOR CHILD:** I hereby authorize this office to administer chiropractic care as deemed necessary for my child.

Signature \_\_\_\_\_ (Parent/Legal Guardian) Date \_\_\_\_\_

**FINANCIAL/ INSURANCE POLICY:**

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that the Doctor's Office will process 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.

Signature \_\_\_\_\_ Date \_\_\_\_\_

**AUTHORIZATION TO RELEASE INFORMATION**

To: Ria Tjong

You are authorized to release any information you deem appropriate concerning my physical condition to any insurance company, attorney, or adjuster in order to process any claim for reimbursement of charges incurred by me as a result of professional services rendered by you, and I hereby release you of any consequence thereof.

Signature \_\_\_\_\_ Date \_\_\_\_\_

Witness \_\_\_\_\_