Highland Chiropractic Clinic, Inc.

Dr. Larry R. Vance, D.C., C.C.S.P.
480 E Winchester St Suite 150
Murray, Utah 84107
(801) 277-5665

Information/Application for Care

The following information is needed in order to better serve you. Please complete all questions. If you need assistance, please ask the receptionist.

Please Print:

Name: ______________________________ Home:_____________ Cell: _____________ Work:______________

Address: _____________________________ City ______________ State ____ Zip __________

Date of Birth ___/___/___ Marital Status: S M W D # of Children ____ Email: _________________________

Best time to reach you: Morning Afternoon Evenings Can we call you at work? Y N

Please circle on the payment type: Cash Check Master Card/Visa American Express

Your employer _____________________ Occupation ________________ Years on the Job _____

Employer address ________________________City ____________ State______ Zip_________

Insurance Company ________________________________ Your SSN ______________________

Do you have Medicare? ____Yes ____No

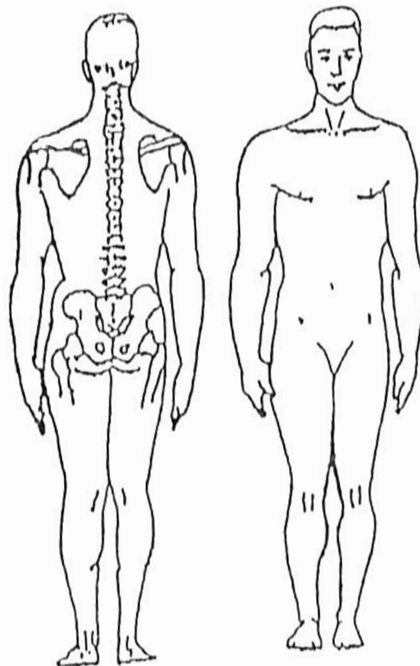
Name of Spouse or Parent _______________________________ Date of Birth ____/____/____

Spouse Employer ________________________ Occupation _______________ Yrs on Job ____

Employer Phone _________________ 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 of pain, as well as any activity which brings on or aggravates the pain. For example, dull, sharp, consistent, on and off, when standing, when sitting etc.



Major Complaints
(Please list any condition you are being treated for or experiencing)

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____
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____

Referred to our office by: __________________________

How payment will be made:

_____ Cash _____ Workman's Comp _____ Health Insurance

_____ Check _____ Credit Card _____ Auto Insurance

Is your condition due to an accident? _____ Yes _____ No If yes, Date of accident ___/___/___

Type of accident? _____ Auto _____ Work/On Job _____ At Home _____ Other

Have you ever been in an accident? _____ Past year _____ Past 5 years _____ Over 5 years _____ Never

I (we) agree to pay for services rendered to the above-mentioned patient as charges are incurred. I understand and agree that health 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, all fees for professional services rendered me will be immediately due and payable.

Patient's Signature __________________________ Date _____/_____/_____

Or Guardian Signature ______________________ Date _____/_____/_____

Notice to our new patients: Full payment for services rendered is due at the end of each visit. If for any reason this request cannot be met, arrangements should be made in advance before seeing the doctor.

Insurance cases: On all insurance assignments, the deductible should be met in the beginning unless prior arrangements are made.