DOAN FAMILY CHIROPRACTIC
12411 N Rockwell Ave
Oklahoma City, OK 73142 405-621-5617

Today's Date:

First Name: | Last Name: | Date Of Birth:

Home Phone: | Mobile Phone: | Work Phone:

@E-Mail: | Preferred Communication: (Circle) H M W E@

Street Address: | Apt/Suite #:

City: | ZipCode: | State:

Medicare #:

Gender: ♀ Female ♂ Male

Preferred Language: ❑ English ❑ Other _____

Is Medicare your primary insurance? ❑ Yes ❑ No

Marital Status: ❑ Single ❑ Married ❑ Other ❑ Divorced ❑ Widowed ❑ Separated

Emergency Contact Name: | Phone: | Relationship:

Reason For Your Visit

❑ Wellness & Health Maintenance

❑ Injury, Pain Complaint, or Ailment — Date Of Injury (When Did Your Pain Start?)

❑ Accident ❑ Automobile Related Accident ❑ Other Type Of Accident — Date Of Accident: | State: Where Accident Occurred

briefly describe your symptoms and conditions that have brought your here:

Doan Family Chiropractic Patient Financial Agreement

Initial Examination: Including, but not limited to the following: patient conference, review of history, extended spinal exam, extremity exam if indicated, patient education relating to chiropractic, 1st adjustment and other exams necessary to effectively treat you.
Initial exam and adjustment.....$140.00

Adjustments: (including extremities)..... $50.00
Medicare.....$40.00
Children under 18 .....$35.00

A parent or legal guardian must accompany a child under 18.

We do not diagnose or treat any disease. We find and eliminate the interference to the expression of the body's innate wisdom.

Initial here:_____

We do not accept insurance, however, we will provide you with a form that you can submit to your insurance company for reimbursement. ALL FEES ARE DUE AT TIME OF SERVICE.
NOTE: Medicare will only pay for services that it determines to be reasonable and necessary under Section 1862(a)(1) of the Medicare Law. Therefore, Medicare may deny payment for services performed at Doan Family Chiropractic.
I have been informed by Dr. Doan that Medicare may not pay for my services rendered at Doan Family Chiropractic. I understand that if Medicare denies payment for any or all services performed at Doan Family Chiropractic, I agree to be personally and fully responsible for payment to Doan Family Chiropractic.

Signature: _____ Date: _____

COMPLETE THIS SECTION ONLY IF PATIENT IS A MINOR:
How was your child born? (Vaginal, cesarean, breech, etc.) _____
Has your child been vaccinated? Y/N Last vaccination: _____
Vaccination side effects: _____
I authorize Doan Family Chiropractic to care for my child.
Parent's signature: _____ Date: _____

PRIVACY PRACTICES ACKNOWLEDGEMENT

ACKNOWLEDGEMENT FORM

I have received the Notice of Practices and I have been provided an opportunity to review it.

Name:_____ Birthdate:____/____/____

Signature:_____

Date::____/___/____