FILL OUT COMPLETELY – PLEASE PRINT

Name_____ Birth Date_____ SS# _____

Address_____ City_____ State_____ Zip_____

Marital Status: S M W D Sep #Children_____ Home Phone_____ Work Phone_____

Employer_____ Occupation_____ Email Address_____

Spouse's Name_____ Occupation_____ Ladies, are you pregnant? __Yes __No

How did you hear about us? __Phone book __ Ad __Sign __Referral–Name_____

Chiropractic before? __Y __N If yes, when? _____ Doctor's Name _____

Briefly describe complaints _____

_____

_____

Other Doctors seen for Complaints_____ When_____

Are complaints caused by an Auto Accident? ___Yes ___No (If yes, ask for injury form to fill out.)

Are complaints caused by a Work Injury? ___Yes ___No (Must have Employers Authorization before ANY Treatment)

List ALL surgeries and dates_____

List ALL drugs you are taking_____

List ALL vitamins you are taking_____

Have you EVER been diagnosed as having or suffering from:

___Broken or Fractured Bones
___Rheumatoid Arthritis
___Seizures/Convulsions
___A Congenital Disease
___Excessive Bleeding
___High/Low Blood Pressure
___Circulation Problems
___Epilepsy
___Osteoarthritis
___Pace Maker
___Strokes
___Cancer
___Ulcers
___Ruptures
___Coughing Blood
___Eating Disorder
___Alcoholism
___Drug Addiction
___HIV Positive
___Gall Bladder
___Head Problems
___Depression
___Tumors
Other_____

Payment Arrangements: (Check One) ___Cash/Check ___Credit Card ___ Insurance (Must be verified in advance)

READ CAREFULLY – IF YOU UNDERSTAND AND AGREE, SIGN BELOW

Authorization & Assignment: I hereby authorize and assign any and all insurance and/or third party benefits directly to Dr. Alan Schwartz and this office. I authorize the release of any and all information he deems necessary to anyone in order to process a claim for insurance or third party benefits on my behalf, and hereby release him of any consequences thereof.

I hereby authorize the doctor to treat my condition as he deems appropriate through the use of spinal adjustments (manipulation) and therapy throughout my spine/body. I understand and agree the amount paid the doctor for x-rays, is for examination and analysis of the x-rays only and the x-ray negatives will remain the property of this office. The doctor will not be held responsible for any pre-existing medically diagnosed conditions or medical diagnosis. I agree that I am responsible for any and all charges at this office whether paid by insurance or not.

I give Dr. Alan Schwartz consent to treat me / my minor children. All information is true to the best of my knowledge.

Signature_____ Date_____
(Patient - Guardian)