## WELCOME

Relationship to Patient   Insurance Co.	Relationship to Patient   D #	PATIENT INFORMATION	INSURANCE
Insurance Co.   Group #   Is patient covered by additional insurance?   Yes   No   Subscriber's Name   Side   Si	Patient Name	Date	Who is responsible for this account?
First Name	First Name	SS/HIC/Patient ID #	Relationship to Patient
Group #	First Name	The first state of the first sta	Insurance Co.
Signature of Patient, Parent, Guardian or Personal Representative   Sign	Signature of Patient, Parent, Guardian or Personal Representative   Phone   Phone   Patient	Last Name	
Subscriber's Name Birthdate SS# Relationship to Patient Insurance Co. Group # ASSIGNMENT AND RELEASE I certify that I, and/or my dependent(s), have insurance coverage and assign direct Name of Insurance Company(ies) and assign direct firany, otherwise payable to me for services rendered. I understand that financially responsible for all charges whether or not paid by insuran authorize the use of the purpose of obtaining payment services and determining insurance benefits or the purpose of obtaining payment reservices and determining insurance to the purpose of obtaining payment reservices and determining insurance to the purpose of obtaining payment reservices and determining insurance to the purpose of obtaining payment reservices and determining insurance to the purpose of obtaining payment reservices and determining insurance to the purpose of obtaining payment reservices and determining insurance to the purpose of obtaining payment reservices and obtaining payment reservices and determining insurance to the purpose of obtaining payment reservices and obtaining payment	Subscriber's Name Birthdate SS# Relationship to Patient	First Name Middle Initial	
Birthdate	Birthdate SS# Relationship to Patient Insurance Co. Group # ASSIGNABENT AND RELEASE   certify that I, and/or my dependent(s), have insurance coverage   certify that I, and/or my dependent(s), have insurance coverage   certify that I, and/or my dependent(s), have insurance coverage   certify that I, and/or my dependent(s), have insurance coverage   certify that I, and/or my dependent(s), have insurance coverage   certify that I, and/or my dependent(s), have insurance coverage   certify that I, and/or my dependent(s), have insurance coverage   certify that I, and/or my dependent(s), have insurance coverage   certify that I, and/or my dependent(s), have insurance coverage   certify that I, and/or my dependent(s), have insurance coverage   certify that I, and/or my dependent(s), have insurance coverage   certify that I, and/or my dependent(s), have insurance coverage   certify that I, and/or my dependent(s), have insurance coverage   certify that I, and/or my dependent(s), have insurance coverage   certify that I, and/or my dependent(s), have insurance coverage   certify that I, and/or my dependent(s), have insurance coverage   certify that I, and/or my dependent(s), have insurance coverage   certify that I, and/or my dependent(s), have insurance coverage   certify that I, and/or my dependent(s), have insurance coverage   certify that I, and/or my dependent(s), have insurance coverage   certify that I, and/or my dependent(s), have insurance coverage   certify that I, and/or my dependent(s), have insurance coverage   certify that I, and/or my dependent(s), have insurance coverage   certify that I, and/or my dependent(s), have insurance coverage   certify that I, and/or my dependent(s), have insurance coverage   certify that I, and/or my dependent(s), have insurance coverage   certify that I, and/or my dependent(s), have insurance coverage   certify that I, and/or my dependent(s), have insurance coverage   certify that I, and/or my dependent(s), have insurance coverage   certify that I, and/or my dependent(s), have i	SS	
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Insurance Co.  Group # ASSIGNMENT AND RELEASE   certify that i, and/or my dependent(s), have insurance coverage and assign direct   Name of Insurance Company(ies)   Dr	Insurance Co. Group # ASSIGNMENT AND RELEASE   certify that I, and/or my dependent(s), have insurance coverage in and assign directly nated in provided in partnered for years aftion at temployer/School directly syer/School Address.  It employer/School Address aftion at temployer/School address aftion at temployer/School Address are selected. I understand that I financially responsible for all charges whether or not paid by insurance benefit any, otherwise payable to me for services rendered. I understand that I financially responsible for all charges whether or not paid by insurance year information to the above-named doctor may use my health care information and may discuss information to the above-named insurance Company(les) and their agriculture of patient payment for services and determining insurance information to the above-named doctor may use my health care information and may discuss the propose of obtaining payment for services and determining insurance information to the above-named insurance Company(les) and their agriculture of patient payment for services and determining insurance information to the above-named insurance coverage in any dashed that I financially responsible for all charges whether or not paid by insurance constraints and their agriculture of all charges whether or not paid by insurance in any displayment for services and determining insurance of the payment for services and determining insurance of payment for services and determining insurance of pa		
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Dr	Dr.		and assign directly to
if any, otherwise payable to me for services rendered. I understand that financially responsible for all charges whether or not paid by insuran authorize the use of my signature on all insurance submissions.  The above-named doctor may use my health care information and may dis such information to the above-named insurance Company(ses) and their as for the purpose of obtaining payment for services and determining insurance submissions.  The above-named doctor may use my health care information and may dis such information to the above-named insurance Company(ses) and their as for the purpose of obtaining payment for services and determining insurance submissions.  The above-named doctor may use my health care information and may dis such information to the above-named insurance Company(ses) and their as for the purpose of obtaining payment for services and determining insurance users in the payment for services and determining insurance users in the payment for services and determining insurance users in the payment for services and determining insurance users in the payment for services and determining insurance users in the payment for services and determining insurance users in the payment for services and determining insurance users in the payment for services and determining insurance users in the payment for services and determining insurance users in the payment for services and their as for the payment for services and determining insurance users in the payment for services and determining insurance users in the payment for services and determining insurance users in the payment for services and determining insurance users in the payment for services and determining insurance users in the payment for services and determining insurance users in the payment for services and determining insurance users in the payment for services and determining insurance users in the payment for services and determining insurance users in the payment for services and determining insurance users in the payment for services	if any, otherwise payable to me for services rendered. I understand that I financially responsible for all charges whether or not paid by insurance authorize the use of my signature on all insurance submissions.  The above-named doctor may use my health care information and may disc such information to the above-named insurance Company(ies) and their ag for the purpose of chaining payment for services and determining insurance authorize the use of my signature on all insurance Company(ies) and their ag for the purpose of chaining payment for services and determining insurance authorize the use of my signature on all insurance company(ies) and their ag for the purpose of chaining payment for services and determining insurance and the purpose of patient for services and determining insurance authorize the use of my signature on all insurance company(ies) and their ag for the purpose of patient for services and determining insurance benefits or the benefits payable for related services. This consent will end we my current treatment plan is completed or one year from the date signed between the purpose of Patient, Parent, Guardian or Personal Representative Please print name of Patient, Parent, Guardian or Personal Representative Please print name of Patient, Parent, Guardian or Personal Representative Please print name of Patient, Parent, Guardian or Personal Representative Please print name of Patient, Parent, Guardian or Personal Representative Please print name of Patient, Parent, Guardian or Personal Representative Please print name of Patient, Parent, Guardian or Personal Representative Please print name of Patient, Parent, Guardian or Personal Representative Please print name of Patient, Parent, Guardian or Personal Representative Please print name of Patient, Parent, Guardian or Personal Representative Please print name of Patient, Parent, Guardian or Personal Representative Please print name of Patient, Parent, Guardian or Personal Representative Please print name of Patient, Parent, Guardian or Personal R		
authorize the use of my signature on all insurance submissions.  The above-named doctor may use my health care information and may dissuch information to the above-named Insurance Company(les) and their as such information to the above-named Insurance Company(les) and their as such information to the above-named Insurance Company(les) and their as such information to the above-named Insurance Company(les) and their as such information to the above-named Insurance Company(les) and their as such information to the above-named Insurance Company(les) and their as such information to the above-named Insurance Company(les) and their as such information to the above-named Insurance Company(les) and their as such information to the above-named Insurance Insurance Information and may dissuch information to the above-named Insurance submissions.  The above-named doctor may use my health care information and may dissuch information to the above-named Insurance Insurance Information and may dissuch information and may dissurb informat	authorize the use of my signature on all insurance submissions.  The above-named doctor may use my health care information and may disc such information to the above-named linsurance Company(ies) and their ag for the purpose of obtaining payment for services and determining insurable for related services. This consent will end we my current treatment plan is completed or one year from the date signed be signature of Patient, Parent, Guardian or Personal Representative Please print name of Patient, Parent, Guardian or Personal Representative Please print name of Patient, Parent, Guardian or Personal Representative Please print name of Patient, Parent, Guardian or Personal Representative Please print name of Patient, Parent, Guardian or Personal Representative Please print name of Patient, Parent, Guardian or Personal Representative Please print name of Patient, Parent, Guardian or Personal Representative Please print name of Patient, Parent, Guardian or Personal Representative Please print name of Patient, Parent, Guardian or Personal Representative Please print name of Patient, Parent, Guardian or Personal Representative Please print name of Patient, Parent, Guardian or Personal Representative Please print name of Patient, Parent, Guardian or Personal Representative Please print name of Patient, Parent, Guardian or Personal Representative Please print name of Patient, Parent, Guardian or Personal Representative Please print name of Patient, Parent, Guardian or Personal Representative Please print name of Patient, Parent, Guardian or Personal Representative Please print name of Patient, Parent, Guardian or Personal Representative Please print name of Patient, Parent, Guardian or Personal Representative Please print name of Patient, Parent, Guardian or Personal Representative Please print name of Patient, Parent, Guardian or Personal Representative Please print name of Patient, Parent, Guardian or Personal Representative Please print name of Patient, Parent, Guardian or Personal Representative Please print name o	Note that the second of the se	if any, otherwise payable to me for services rendered. I understand that I am
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Please print name of Patient, Parent, Guardian or Personal Representations be's Employer  m may we thank for referring you?  Date Relationship to Patient  ACCIDENT INFORMATION  Is condition due to an accident?  Yes No  Date  Type of accident  Auto  Work Home Other  To whom have you made a report of your accident?  Auto Insurance  Employer Worker Comp. Other  Attorney Name (if applicable)	Please print name of Patient, Parent, Guardian or Personal Representative many we thank for referring you?  Date Relationship to Patient  PHONE NUMBERS  ACCIDENT INFORMATION  Is condition due to an accident? Yes No  Date  Type of accident Auto Work Home Other  To whom have you made a report of your accident?  Auto Insurance Employer Worker Comp. Other  Attorney Name (if applicable)	se's Name	my current against plan is completed of one year normal and any
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PHONE NUMBERS  ACCIDENT INFORMATION  Is condition due to an accident? Yes No  Date  Type of accident Auto Work Home Other  To whom have you made a report of your accident?  Name  Relationship  Home Phone ()  Relationship  Home Phone ()  Attorney Name (if applicable)	PHONE NUMBERS  ACCIDENT INFORMATION  Is condition due to an accident? \  Yes \  No  Date  Type of accident \  Auto \  Work \  Home \  Other  To whom have you made a report of your accident?  Attorney Name (if applicable)  Work Phone (\  )  Work Phone (\  )  Work Phone (\  )		
PHONE NUMBERS  ACCIDENT INFORMATION  Is condition due to an accident? Yes No  Date  Type of accident Auto Work Home Other  To whom have you made a report of your accident?  Auto Insurance Employer Worker Comp. Other  Attorney Name (if applicable)	PHONE NUMBERS    Cell Phone ()	se's Employer	Please print name of Patient, Parent, Guardian or Personal Representative
PHONE NUMBERS    ACCIDENT INFORMATION	PHONE NUMBERS    ACCIDENT INFORMATION		Date Relationship to Patient
Is condition due to an accident?   Yes   No	Is condition due to an accident?   Yes   No		
Date	Date   Type of accident   Auto   Work   Home   Other	PHONE NUMBERS	ACCIDENT INFORMATION
Best time and place to reach you IN CASE OF EMERGENCY, CONTACT  Name  Relationship Home Phone ()  Type of accident	Best time and place to reach you		ls condition due to an accident? ☐ Yes ☐ No
IN CASE OF EMERGENCY, CONTACT  Name  Relationship  Home Phone ()  Name (if applicable)  To whom have you made a report of your accident?  Attorney Name (if applicable)	IN CASE OF EMERGENCY, CONTACT  Name  Relationship  Home Phone ()  Work Phone ()	Cell Phone ()	_ Date
Name To whom have you made a report of your accident?  Auto Insurance  Employer  Worker Comp. Other  Attorney Name (if applicable)	Name	Best time and place to reach you	Type of accident ☐ Auto ☐ Work ☐ Home ☐ Other
Relationship Attorney Name (if applicable)	Relationship Attorney Name (if applicable)  Work Phone ()		To whom have you made a report of your accident?
Home Phone ()	Home Phone ()  Work Phone ()		5
	Work Phone ()		Attorney Name (II applicable)
	PATIENT CONDITION		
PATIENT CONDITION			TIENT CONDITION
Reason for Visit		When did your symptoms appear?	□No □Unknown
When did your symptoms appear?	When did your symptoms appear?	Mark an X on the picture where you continue to have to	pain, numbness, or tingling.
When did your symptoms appear?  Is this condition getting progressively worse?   Yes   No  Unknown	Is this condition getting progressively worse?   Yes   No   Unknown	Rate the severity of your pain on a scale from 1 (least pair	n) to 10 (severe pain)
When did your symptoms appear?  Is this condition getting progressively worse?   Yes   No   Unknown  Mark an X on the picture where you continue to have pain, numbness, or tingling.  Rate the severity of your pain on a scale from 1 (least pain) to 10 (severe pain)	Is this condition getting progressively worse?   Yes   No   Unknown  Mark an X on the picture where you continue to have pain, numbness, or tingling.  Rate the severity of your pain on a scale from 1 (least pain) to 10 (severe pain)	Type of pain: Sharp Dull Throbbing	Numbness □ Aching □ Shooting □ (*)   り (*)   り
When did your symptoms appear?  Is this condition getting progressively worse?   Yes  No  Unknown  Mark an X on the picture where you continue to have pain, numbness, or tingling.  Rate the severity of your pain on a scale from 1 (least pain) to 10 (severe pain)  Type of pain:  Sharp  Dull  Throbbing  Numbness  Aching  Shooting	Is this condition getting progressively worse?	w often do you have this pain?	
When did your symptoms appear?  Is this condition getting progressively worse?	Is this condition getting progressively worse?	it constant or does it come and go?	
When did your symptoms appear?  Is this condition getting progressively worse?  See No Unknown  Mark an X on the picture where you continue to have pain, numbness, or tingling.  Rate the severity of your pain on a scale from 1 (least pain) to 10 (severe pain)  Type of pain:  Sharp  Dull  Numbness  See Swelling  Shooting  Burning  Tingling  Cramps  Stiffness  Swelling  Other  ow often do you have this pain?	Is this condition getting progressively worse?	IL SOLIDARITY OF MOSO IL SELIES MINE SOLI	1111

## **HEALTH HISTORY**

What treatment hav	e you already	eceived for your condit	tion? 🗌 M	edication	s Surgery	Physical	Therapy				
	hiropractic Ser	vices	☐ Other								
Name and address	of other doctor	(s) who have treated y	ou for you	conditio	on						
Date of Last: Phys	sical Exam		Spinal X	Ray			_ Bloc	Blood Test			
Spir	nal Exam		Chest X-	Ray			Urin	e Test			
			one Scan								
		dicate if you have had									
AIDS/HIV	Yes N		☐ Yes		Liver Disease	Yes	□No	Rheumatic Fever	☐ Yes	☐ No	
Alcoholism	☐ Yes ☐ N		☐ Yes	Minute Control	Measles	☐ Yes	□ No	Scarlet Fever	☐ Yes	☐ No	
Allergy Shots	_ Yes □ N		☐ Yes	□No	Migraine Headaches	s ☐ Yes	☐ No	Sexually			
Anemia	☐ Yes ☐ N	the Thister Construction of	☐ Yes	□No	Miscarriage	☐ Yes	☐ No	Transmitted Disease	Yes	□No	
Anorexia	☐ Yes ☐ N	Glaucoma	☐ Yes	□ No	Mononucleosis	☐ Yes	□ No	Stroke	☐ Yes	□ No	
Appendicitis	☐ Yes ☐ N	Goiter	☐ Yes	☐ No	Multiple Sclerosis	Yes	□ No	Suicide Attempt	Yes	□No	
Arthritis	☐ Yes ☐ N	Gonorrhea	☐ Yes	☐ No	Mumps	☐ Yes	☐ No	Thyroid Problems	☐ Yes	□No	
Asthma	☐ Yes ☐ N	o Gout	☐ Yes	☐ No	Osteoporosis	Yes	☐ No	Tonsillitis	☐ Yes		
Bleeding Disorders	Yes N	Heart Disease	☐ Yes	☐ No	Pacemaker	☐ Yes	□ No	Tuberculosis	☐ Yes	☐ No	
Breast Lump	☐ Yes ☐ N	o Hepatitis	☐ Yes	☐ No	Parkinson's Disease	e 🗌 Yes	□ No	Tumors, Growths	☐ Yes	□ No	
Bronchitis	☐ Yes ☐ N	o Hernia	☐ Yes	☐ No	Pinched Nerve	☐ Yes	□ No	Typhoid Fever	☐ Yes	☐ No	
Bulimia	☐ Yes ☐ N	Herniated Disk	☐ Yes	□No	Pneumonia		☐ No	Ulcers	☐ Yes	☐ No	
Cancer	☐ Yes ☐ N	o Herpes	☐ Yes	☐ No	Polio	☐ Yes		Vaginal Infections	Yes	☐ No	
Cataracts	☐ Yes ☐ N	o High Blood Pressure	☐ Yes	□No	Prostate Problem	Yes		Whooping Cough	☐ Yes	☐ No	
Chemical	□ Yes □ N		9 4	□ No	Prosthesis	Yes		Other			
Dependency Chicken Pox	☐ Yes ☐ N			□ No	Psychiatric Care Rheumatoid Arthriti	Yes	THE WALLEST OF				
None		Standing	.14111		HABITS  ☐ Smoking  ☐ Alcohol			/Day			
		Standing				rinke		Day			
☐ Daily		☐ Light Labor			☐ Coffee/Caffeine D			57V-3			
Heavy		☐ Heavy Labor			☐ High Stress Level		Reas	on			
Are you pregnant?	☐ Yes ☐ N	Due Date									
Injuries/Surgeries y Falls Head Injuries	-		Descr	iption				Date			
Broken Bone							L :				
VALUE OF THE PARTY OF THE	5										
Dislocations											
Surgeries							_				
M	EDICATI	ONS		ALLE	ERGIES	VIT	AMI	NS/HERBS/I	AINE	RAL	
										-	
Pharmacy Name_											