WELCOME TO HEALING HANDS CHIROPRACTIC

Name:_____ SS#:_____

Address:_____City:_____ State____ Zip_____

Sex: ☐ Male ☐ Female Date of Birth:_____ Age:_____

Home #:_____ Work #:_____

Cell #:_____Email:_____

What is our easiest way to contact you? ☐ Home # ☐Cell # ☐Email

Are you: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Spouse's Name:_____ Children's Name:_____

Your Employer:_____

Whom may we thank for referring you to us?_____

Do you have Insurance? ☐ Yes ☐ No

Insurance Co:_____

Name of Insured:_____ Insured date of birth:_____

Relationship to Insured:_____ ID#_____

PLEASE GIVE US A COPY OF YOUR INSURANCE CARD

Reason for visit:_____

When did you first notice problem:_____

What activities are difficult to perform: ☐Sitting ☐Standing ☐Walking ☐Bending ☐Lying Down

Type of Pain: ☐Sharp ☐Dull ☐Throbbing ☐Aching ☐Shooting ☐Burning ☐Tingling ☐Cramps ☐Stiffness ☐Swelling

What are you doing for this problem:_____

Have you had any spinal surgeries: ☐ Yes ☐ No

Are you aware of any spinal abnormalities: ☐ Yes ☐ No

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the chiropractor to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such chiropractic care to third party payers and/or health practitioners. I authorize and request my insurance company to pay directly to Healing Hands Chiropractic otherwise payable to me. I understand that my chiropractic insurance carrier may pay less than the actual for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents. We accept payment by Cash, Check or Credit Card.

Patient Signature: _____ Date:_____