Downs Chiropractic, Inc.
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Board Certified in Chiropractic Orthopedics

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WELCOME

ABOUT YOU...

Today's Date:___/___/___

Name:_____ ☐ Male ☐ Female Birthdate:___/___/___ Age:_____

What You Prefer To Be Called:_____ E-Mail:_____

Home Address:_____
Street City State Zip

Home Phone:_____ Mobile Phone:_____ Soc.Sec.#:_____

Referred By:_____ Employer:_____ Occupation:_____

How Long There:_____ Work Phone:_____

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed Number of Children _____

Spouse's Name:_____ Work Phone:_____ Employer:_____

Who Should We Contact In The Event Of An Emergency?_____ Relationship:_____

Their Home Phone:_____ Their Work Phone:_____

PRIMARY CARE PHYSICIAN...

Doctor's Name:_____ Phone: _____

Address: _____
Street City State Zip

PLEASE INFORM FRONT DESK STAFF OF SECONDARY INSURANCE SOURCE
Please Provide Front Desk Staff with Your Driver's License or ID
We invite you to discuss with us any questions regarding our services.
The best health services are based on a friendly, mutual understanding between provider and patient.

REASON FOR VISIT...

↳ Have you ever been treated by a chiropractor before? ☐ Yes ☐ No. If so, please explain:_____

↳ The reason for this visit is a result of (circle): work/sports/auto/trauma/chronic/unknown mechanism of injury. Explain what happened:_____

↳ Please describe the pain and its location:_____

↳ Secondary complaint(s):_____

↳ Date of onset:___/___/___ Is condition getting worse? ☐ Yes ☐ No ☐ Constant ☐ Comes/Goes

↳ Is condition interfering with (circle): work/sleep/daily routine? If so, please explain: _____

↳ Was this condition treated by a medical physician? ☐ Yes ☐ No If so, where?_____

↳ Were x-rays taken? ☐ Yes ☐ No

HEALTH HISTORY...

Are you taking any of the following medications?

☐ Nerve Pills ☐ Pain Killers (including aspirin) ☐ Muscle Relaxers ☐ Stimulants
☐ Blood Thinners ☐ Tranquilizers ☐ Insulin ☐ Other(s)_____

Circle the following disease(s) you currently have or have had in the past:

Alcohol/Drug Abuse	Cancer	Fainting/Seizures/Epilepsy	Hepatitis	Psychiatric Problems
Anemia	Chemotherapy	Frequent Neck Pain	High/Low Blood Pressure	Rheumatic Fever
Arthritis	Congenital Heart Defect	Headaches-Frequent/Severe	HIV+/AIDS	Shingles
Artificial Bones/Joint	Diabetes/Tuberculosis	Heart Attack/Stroke	Kidney Problems	Sinus Problems
Artificial Valves	Difficulty Breathing	Heart Murmur	Lower Back Problems	Ulcers/Colitis
Asthma	Emphysema/Glaucoma	Heart Surgery/Pacemaker	Mitral Valve Prolapse	Venereal Disease

↳ List any other serious medical condition(s) you have or ever had:_____
↳ List anything you may be allergic to:_____
↳ List previous surgeries/treatments with dates:_____
↳ List past serious accidents with dates:_____
Do you smoke? ☐ Yes ☐ No How much?_____ How long?_____
Are you wearing: ☐ Heel lifts ☐ Sole lifts ☐ Inner soles ☐ Arch supports
For Women: Are you taking birth control? ☐ Yes ☐ No
Are you pregnant? ☐ No ☐ Yes How long?_____ Nursing? ☐ Yes ☐ No

ACCOUNT INFO...

Person ultimately responsible for the account: ☐ Same ☐ If other than patient:
Name:_____ Relationship:_____ Phone:_____
Address:_____ City:_____ State:_____ Zip:_____
Credit Card #:_____ Type:_____ Exp:_____ Security Code:_____
(Visa/MC/Disc, etc)

☐I hereby authorize assignment of my insurance rights and benefits directly to the provider for services rendered.

↳ **Our policy** requires payment in full for all services rendered at the time of visit unless other arrangements have been made with this office. If the account is not paid within 90 days of the date of service and no financial arrangements have been made, you will be responsible for any expenses incurred in our collection efforts, including reasonable attorney's fees.
↳ **I understand** that by providing my insurance card or information, this office will attempt to verify and confirm the details details and parameters of my insurance coverage for chiropractic healthcare. I understand and agree that health policies are an arrangement between me and an insurance provider. I request that payment of benefits on my behalf be made to Downs Chiropractic for any services furnished to me. I understand that regardless of any insurance coverage I may have, it is my responsibility to pay my bill. I further understand that my insurance is designed to reimburse Downs Chiropractic for covered expenses. I understand further that not all services are covered by insurance plans and acknowledge that I am responsible and will pay for those services. Furthermore, I understand that this office will prepare any necessary reports and forms to assist in making collection from the insurance company and that any amounts authorized to be paid directly to Downs Chiropractic will be credited to my account upon receipt.
↳ **I authorize** Downs Chiropractic to release any information concerning my care, which is necessary for claims processing, to the appropriate insurance company and/or attorney that may be involved with my case. However, I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment.
↳ **I authorize** the staff to perform any necessary services needed during diagnosis and treatment.
↳ **I understand** the above information and guarantee this form was completed accurately to the best of my knowledge, and I understand it is my responsibility to inform this office of any changes in my medical status.

_____ _____
Patient Signature Today's Date