ABRAMS CHIROPRACTIC CLINIC PLLC

Lee M Phelps D.C.

Date _____

Name _____ Age _____ Birthdate_____ Sex _____

Address _____ City _____ State _____Zip_____

Cell Phone _____ E-mail_____

Preferred form of Appointment Reminder: □ E-mail □ Text (if so carrier_____)

Marital Status: (circle one) Single Married Widowed Divorced Separated How Many Children? _____

Occupation _____ Employer _____

Address _____ City _____ Zip _____

Name of Spouse _____ Occupation _____

Date of last physical exam _____ How did you hear about our office? _____

Chief Complaint _____

When did it start? _____ □ Worse □ Same □ Better

Other doctors seen for this condition _____

Results of treatment _____

Have you had this condition before? □Yes □No If so, when? _____

Medical History (please select any box relevant to your history)

○ Cancer	○ Muscular Dystrophy	○ Rheumatic Fever	○ Osteoporosis
○ Polio	○ Multiple Sclerosis	○ Scarlet Fever	○ Anemia
○ Tuberculosis	○ Convulsions	○ Nervousness	○ Numbness
○ High Blood Pressure	○ Epilepsy	○ Asthma	○ Backaches
○ Heart Trouble	○ Concussion	○ Digestive Disorders	○ Sinus Trouble
○ Diabetes	○ Dizziness	○ Hepatitis	○ Venereal Disease
○ German Measles	○ Neuritis	○ Rheumatism	○ Arthritis

Have you been treated for any other health conditions this year? □ Yes □No if so, what? _____

Describe the operations you have had _____When? _____

Have you had any bad falls? Describe _____ When? _____

Have you had any broken bones? Describe _____ When? _____

Are you taking medication? □Yes □No If yes, What kind? _____

Have you seen a chiropractor before? □Yes □No Who? _____

Are you or is there any chance that you may be Pregnant? □Yes □No

14326 Greenwood Ave N Seattle, WA 98133
Phone: (206) 789-5704
Fax: (206) 782-6432
mydoctor@abramschiropractic.com
www.abramschiropractic.com

I understand and agree that the health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that Dr. Phelps and associates will prepare any necessary reports and forms to assist me in collecting from the insurance company. An amount authorized will be paid directly to the aforementioned doctor and will be credited to my account on receipt. I also give this office power of attorney to endorse checks made out to me to be credited to my account. 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 also understand that if I suspend or terminate my care and treatment, any fees for professional service rendered to me will be immediately due and payable.

I certify that, to the best of my knowledge, the information provided is correct and I understand that interest will be charged on all overdue accounts at 18% annual percentage rate.

Patient Signature _____ Date _____

Parent or Guardian Signature _____ Date _____

Driver's License Number _____ Date _____

Assignment and instruction for direct payment to the doctor private and group accident and health insurance

Patient _____ Insured _____

Group# _____ SS/ID# _____ I hereby

instruct and direct the _____insurance company to pay by check made out and mailed directly

to: **Abrams Chiropractic Clinic PLLC** 14326 Greenwood Ave N Seattle, WA 98133

If my current policy prohibits direct payment to the doctor, then I hereby also instruct and direct the insurer to make the check to me and mail as follows: **Abrams Chiropractic Clinic PLLC** 14326 Greenwood Ave N Seattle, WA 98133

The professional or medical expense benefits allowable and otherwise payable to me under my current insurance policy as payment toward and total charges for professional services rendered. THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY. This payment will not exceed my indebtedness to the above-mentioned assignee, and I have agreed to pay, in a current manner, any balance of said professional services and charges over and above this insurance payment.

A PHOTOCOPY OF THIS ASSIGNMENT SHALL BE CONSIDERED AS EFFECTIVE AND VAILD AS THE ORIGINAL.

I also authorize any information pertinent to my case to any company, adjuster or attorney involved in this case.

Patient Signature _____ Date _____

Signature of Policy Holder _____ Date _____