Lee M. Phelps, D.C.

ABRAMS CHIROPRACTIC CLINIC

Date_____

Name_____ Age_____ Birthdate_____ Sex_____

Address_____City_____ State_____ Zip_____

Cell Phone_____ Work Phone_____ Email_____

Marital Status: (circle one) Married Single Widowed Divorced Separated How many children?____

Occupation_____ Employer_____

Address_____ City_____ Zip_____

Name of Spouse_____ Occupation_____

Date of last physical exam_____ Social Security Number_____

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 medical history.)

☐ Cancer	☐ Muscular Dystrophy	☐ Rheumatic Fever	☐ Anemia
☐ Polio	☐ Multiple Sclerosis	☐ Scarlet Fever	☐ Numbness
☐ Tuberculosis	☐ Convulsions	☐ Nervousness	☐ Backaches
☐ High Blood Pressure	☐ Epilepsy	☐ Asthma	☐ Sinus Trouble
☐ Heart Trouble	☐ Concussion	☐ Digestive Disorders	☐ Venereal Disease
☐ Diabetes	☐ Dizziness	☐ Hepatitis	
☐ 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 ever 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? _____
Pregnant, or any chance that you may be? ☐ Yes ☐ No

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that Dr. Lee 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 the rate of 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
7815 Greenwood Ave N
Seattle, WA 98103

If my current policy prohibits direct payment to the doctor, then I hereby also instruct and direct you to make the check to me and mail as follows: Abrams Chiropractic Clinic, PLLC
7815 Greenwood Ave N
Seattle, WA 98103

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 VALID AS THE ORIGINAL.

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

Patient Signature_____ Date_____

Signature of Policy Holder_____ Date_____

Witness_____ Date_____