SUNRISE
HEALTH INSTITUTE

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CONFIDENTIAL CLIENT INFORMATION

Personal Information

Full name (Preferred Name): **Date:**	
Address: **City** **State** **Zip**	
Home phone:	**Work phone:**
Cell phone:	**Please circle best number to call: Home Cell Work**
Email address:	**Social Security Number:**
Date of birth:	**Age:**
No. of children:	**Pregnant? Yes ☐ No ☐**
Names of children: **Ages of children:**	
Marital status: M S W D	**Spouse/guardian name:**
Occupation:	
Employer's name & address:	
Spouse's Occupation/Employer:	
Name of person responsible for account:	
Please allow us to make a copy of your insurance card	**Do you have Medicare coverage?** **Yes ☐ No ☐**
Have you ever seen a chiropractor, physical therapist, or massage therapist before? Yes ☐ No ☐	**Approximate date of last visit ___/___/___**
Previous Provider's Name/City/State:	**Did you see the results you hoped to? Yes ☐ No ☐**
Please check if you are here for any of the following: Motor Vehicle Injury ☐ Work Injury ☐ Other Injury ☐	

Who may we thank for referring you? _____

Addressing What Brought You Into This Office:

What is the reason for your visit today? How long has it been going on?

_____

_____

Are there any other specific concerns?

_____

_____

1) When you were a child, (birth to 12 years), did any of the following occur?

__Fall from changing table
__Tumble down stairs
__Fall out of crib
__Fall from tree or playground
__Involved in car accident
__Fall off bicycle
__Play in a "Jolly Jumper"
__Tonsillitis
__Reaction to vaccination
__Frequent crying spells
__Frequent fevers
__Frequent bouts of diarrhea
__Constipation or stomach pains
__Sleeping Problems
__Frequent colds
__Allergies or asthma
__Colic
__Did not gain weight
__Sports Accident
__Scoliosis
__Bed-wetting
__Hyperactivity/Autism
__Learning difficulties
__Leg/knee pain
__Other_____

Please explain the above_____

_____

_____

2) From adolescence through adulthood, (12-present time), have any of the following occurred?

__Headaches/Migraines
__Dizziness
__Allergies/Asthma/Sinus Issues
__Hyperactivity/Autism
__Fatigue
__Attention/focus issues
__Sleeping problems
__Weight gain/loss
__Foot/ankle pains
__Leg/knee pains
__Tingling in arms/legs
__Numbness in arms/hands
__Arm/wrist pains
__Neck/Shoulder pains
__Mid/Lower back pains
__Scoliosis
__Stomach problems
__Played sports
__Sports accidents or injuries
__Car accident
__Anemia
__Calcification of arteries
__Cancer
__Diabetes
__High/Low blood pressure
__Low blood sugar
__Stroke
__Other_____

Please explain the above_____

_____

_____

Current Medicines and Supplements
Please list any medications, supplements, or vitamins that you are currently taking and why:

Date	Name of Medication, Vitamin, or Supplement	Dosage	Dose Schedule	Reason for Taking

Is there anything else you would like for the provider to know?

_____

_____

Our Fee Structure

Consultation	Complimentary
Examination	$ 100.00
Infant Exam	$ 40.00
Adjustment	$ 60.00

Please Note: If you and the provider decide this is the place for you to be, then you will receive an adjustment on your first visit which will be an additional fee. Your clinical Report of Findings, the time that the provider will spend with you to go over your results, will be included with your examination. You will receive an adjustment after your Report of Findings that will be a separate fee.

Insurance and Payment Policy

We are committed to providing you with the best possible care. If you have Chiropractic coverage in your insurance policy, we are willing to help you receive your maximum allowable benefits. In order to achieve this goal, we need your assistance and understanding of our payment policy.

Payment Policy:

1. Full payment is due at time of service. We accept cash, checks, Visa, MasterCard and Discover.
2. We must emphasize that our relationship is with you and not your insurance company. Your insurance policy is a contract between you, your employer, and the insurance company. We are not a party to that contract and therefore do not file your insurance for you. As a courtesy that we extend to our patients, we will provide you with a completed insurance form that you are responsible for filing, which simply means placing it in an envelope and mailing it.
3. Not all services are a covered benefit in all contracts. It will depend on your individual policy.
4. In some cases, once you have met your deductible your insurance company will begin to reimburse you up to an allowed amount. If you have a question about your specific policy and coverage, please call the toll free number on the back of your insurance card and they should be able to answer your questions regarding your policy.
5. Medicare patients are responsible for payment at the time of service because Medicare does not cover services in this office. We will not file claims to Medicare. Medicare patients will sign an Advanced Beneficiary Notice of Noncoverage stating that they understand this and they would still like to receive services.
6. In the case of a Personal Injury accident (car accident or accident at work), our policy stays the same. Payment will still be required upon time of service. All services received will be at our full price for the duration of the Personal Injury case.

There is no fee for consulting with the providers. Fees begin when a problem related to structural misalignment is found and you decide to begin receiving care.

_____I fully understand the above fees and give my consent to consult with the provider and to any BioStructural examination that the provider deems necessary. I understand that any fee for service is due at the time of service and cannot be deferred to a later date.

Print Patient Name: _____ Date: _____

Patient Signature: _____
(Or signature of Parent/Guardian if patient under age 18)

We sincerely thank you for choosing our office and for taking the time to honestly reflect upon and share your current level of health and well-being, as well as your goals.

We look forward to helping you maximize your experience and expression of health and life!