WELCOME

ABOUT YOU

Last Name_____ First Name _____ Middle Init. _____ Age ____

Address _____ Birth date _____

City _____ State _____ Zip _____ Spouse's Name _____

Home Phone # (_____) _____ Work Phone # (_____) _____ Cell Phone # (___) _____

Occupation _____ Employer Name _____ How long have you been employed there? _____

Employer's Address _____ City _____ State ____ Zip _____

Sex: M / F Marital Status: S M D W # Of Children ___ Names/ Ages _____

E-mail Address_____ Referred By: _____

Hobbies/Sports/Interests_____

INSURANCE INFORMATION

Name of Insurance Company: _____ ☐ group ☐ private ☐ auto ☐ work comp

Billing Address: _____

City: _____ State: _____ Zip: _____ Phone Number: _____

Name of Insured: _____ Relationship to patient: _____ Date of birth: _____

Insured's ID#: _____ Group #: _____

Please inform the front desk of any secondary insurance sources.

REASON FOR YOUR VISIT

The reason for this visit is a result of (please check one): ☐ work ☐ sports ☐ auto accident ☐ personal injury ☐ trauma ☐ chronic condition

Please explain what happened: _____

Please describe the pain and its location: _____

When did your present complaint(s) begin? _____ Is it getting (please check): ☐ better ☐ worse ☐ constant ☐ comes and goes

Is this condition interferring with your (please check all that apply): ☐ work ☐ sleep ☐ recreation ☐ daily activities/routine

Have you had this or similar conditions in the past? ☐ yes ☐ no If yes, when? _____

What treatment was received? _____ Who treated you? _____

Have you ever been treated by a chiropractor before? ☐ yes ☐ no Name of chiropractor: _____ Location: _____

PLEASE CONTINUE ON BACK

IN THE EVENT OF AN EMERGENCY

Who should we contact? _____

Relationship to patient:_____

Home phone #: _____ Work Phone #: _____ Cell Phone #: _____

Who is your Medical Doctor? _____ Phone #: _____

ACCOUNT INFORMATION

Person ultimately responsible for account:

Name: _____ Relationship to patient: _____

Billing Address: _____

City: _____ State: _____ Zip: _____ Phone #: _____

Drivers License #: _____ Work Phone: _____

Payment Method: ☐ cash ☐ check ☐ credit **Payment is expected at the time of your visit**

I understand and agree that health and accident inusrance policies are an arrangement between an insurance carrier and myself. I hereby authorize assignment of my insurance rights and benefits directly to the provider for services rendered and I undersand that all monies will be credited to my account upon reciept. I fully understand I am solely responsible for any balance not paid by my insurance company (if offered at this office). _____
INITIALS

COMMUNICATION CHANNELS

To help us better explain your chiropractic condition and how we may be able to help you, please answer the following questions:

1. I remember the important things in my life by: ☐ what I see ☐ what I hear ☐ what I feel
2. The primary reason I brush my teeth is to: ☐ avoid tooth decay/gum disease ☐ make sure I have healthy teeth and gums
3. When I make decisions I generally: ☐ gather facts and weigh the evidence ☐ make the right choice instantly ☐ consult my friends and family ☐ depends on how I feel about it

- We invite you to discuss with us any questions regarding our services. The best health services are based on a friendly, mutual understanding between the provider and the patient.
- Our policy requires payment in full for all services rendered at the time of visit, unless other arrangements have been made. 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 all legal fees, collection agency fees, and any other expenses incurred in collecting your account. I understand that if I suspend or terminate my care and treatment, any fees for professional services rendered me will be immediately due and payable.
- I authorize Dr. Renee J. Gordon and staff to perform any necessary services needed during diagnosis and treatment. I also authorize the provider and/or managed care organization to release any information required to process insurance claims.
- I understand that all appointments must be cancelled with 24-hours notice or I may be charged a cancellation fee.
- I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes to the information I have provided.

Signature: _____ Date: _____
☐ ADULT PATIENT ☐ PARENT/GUARDIAN ☐ SPOUSE