Barnum Chiropractic Center

Patient Personal/Confidential Data

No. _____ Date: _____

Patient: _____ Date of Birth: _____

Physical Address: _____ City: _____ State: _____ Zip: _____

Mailing Address (if different): _____ City: _____ State: _____ Zip: _____

Social Security No.: _____ Home Phone: _____ Work Phone: _____

Employer: _____ Address: _____

Marital Status: _____ Email Address: _____

Name of Spouse: _____ Social Security No.: _____ No. of Children: _____

Spouse's Employer: _____ Address: _____

How did you learn of this clinic: _____

Nearest relative (not living with you): _____ Phone: _____

Who is responsible for payment? ❑Self ❑ Spouse ❑ Other

Patient's Insurance

Name of Company : _____

Address: _____

ID & Group No.: _____

Phone: _____

Spouse's Insurance

Name of Company: _____

Address: _____

ID & Group No.: _____

Phone: _____

Purpose of this appointment and list your complaints: _____

_____

_____

When did illness/injury begin? _____

How did illness/injury occur? ❑ Auto ❑ On the job ❑ Other (please explain)

Please describe the circumstances and what makes the condition(s) better or worse: _____

_____

_____

Are symptoms generally? ❑ Improving ❑ Getting Worse ❑ About the same ❑ Intermittent (comes and goes)

Does this pain radiate? ❑ Yes ❑ No If yes, describe _____

Have you had similar symptoms before? ❑ Yes ❑ No when _____

Effect on Daily Activities? ❑ No effect ❑ Extra effort required ❑ Occasional limitation ❑ Frequent or severe limitation

Current medications taken: _____

Other Doctor seen for this condition: _____

Have you been treated by a Doctor for any health condition in the last year? ❑Yes ❑ No

If yes, please describe: _____

Insurance Information

I understand and agree that health and accident insurance policies are an agreement between an insurance carrier and myself. Furthermore, I understand that this Chiropractic Office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to this Chiropractic Office will be credited to my account upon receipt. 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 services rendered to me will be immediately due and payable.

Signature Patient: _____ Date: _____

Consent of Professional Services and Release of Information

I hereby authorize and release the doctor and whom ever he/she may designate as his/her assistants to administer treatment, physical examination, X-Ray studies, laboratory procedures, chiropractic care or any clinic services that he/she deems necessary in my case; and further I authorize him/her to disclose all or any part of my (patient's) record to any person or corporation which is or may be liable under a contract to the clinic or to the patient or to a family member or employer of the patient for all or part of the clinic's charge, including and not limited to, hospital or medical services companies, insurance companies, workers compensation carriers, welfare funds, or the patient's employer.

Patient's/Parent's or Guardian's Signature: _____

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