INSTRUCTIONS: **Please Print** TODAY'S DATE: _____/_____/_____

NAME: _____MI_____SOCIAL SECURITY # _____-_____-_____
ADDRESS: _____ CITY: _____ STATE _____ ZIP_____
HOME PHONE: (____)_____ WORK PHONE: (____)_____ CELL #: (____) _____
BIRTHDATE: _____/____/_____ AGE: _____ SEX: _____ MARITAL STATUS: S M D W
Mothers Name:_____MI:_____ SSN: _____Employer:_____
Mothers Address_____City,State,Zip_____Mothers Birthdate_____
Fathers Name: _____MI:_____ SSN: _____Employer:_____
Fathers Address_____City,State,Zip_____Fathers Birthdate_____
REFERRED BY: Friend/Relative Newspaper Yellow Pages Sign Other _____
Which one of our patients may we thank for referring you? _____

I am seeking help for (please circle all that apply):

01)	Sinus	08)	Migraines	15)	Hand/Wrist Pain	22)	Foot Pain	29)	Low Back Pain	36)	Weak Immunity
02)	Hip Pain	09)	Jaw - TMJ	16)	Neck Pain	23)	Numbness	30)	Mid Back Pain	37)	Ear Infection
03)	Chest Pain	10)	Asthma	17)	Neck Stiffness	24)	Digestion	31)	Upper Back Pain	38)	Depression
04)	Allergies	11)	Arthritis	18)	Tailbone Pain	25)	Headaches	32)	Menstrual problems		
05)	Arm Pain	12)	Sciatica	19)	General Health	26)	Bedwetting	33)	Fibromyalgia		
06)	Knee Pain	13)	Colic	20)	Nervousness/tension	27)	Leg Pain	34)	Chronic Fatigue Syndrome		
07)	Chronic Infection	14)	Shoulder Pain	21)	Ankle Pain	28)	Elbow Pain	35)	Other:_____		

Other Complaints (please specify): _____

My condition is due to (please circle):

01)	Auto Accident	03)	Sports Accident	05)	Unknown
02)	Accident at Work	04)	Accident at Home	06)	Other

I Desire (please circle): 1) Maximum Improvement **2)** Temporary Relief

Have you ever had spinal surgery? (No) (Yes) Date: _____/_____/_____

Previous Chiropractor: _____ Medical Doctor: _____
When was your last medical physical (approximate date)?: _____/_____/_____

How long has it been since your last Chiropractic adjustment? _____

Females Only: Are you pregnant at this time? (No) (Yes)

I agree to pay for services rendered to the above-mentioned patient as the charge is incurred. I understand and agree that health and accident insurance policies are an arrangement between the insurance carrier and myself and that I am personally responsible for payment of any and all services covered or non-covered. I also understand that if I terminate my care and treatment, any fees for professional services rendered to me will be immediately due and payable. I authorize the release of any personal / medical information to McCormack Chiropractic S.C. to collect or settle any outstanding bills for a period of seven years. I understand that I am responsible for and/all legal costs associated with the collection process.

I authorize the doctor and his staff to release any information deemed appropriate concerning my physical condition to any insurance company, attorney, or adjuster in order to process any claim for reimbursement of charges incurred by me as a result of professional services rendered. I hereby release him/her of any consequence thereof. I agree that a photocopy of this agreement shall serve as the original. I authorize any outside medical exam report/ review to be released to McCormack Chiropractic S.C. upon their request.

I hereby authorize and direct payment of any medical/chiropractic expense benefits allowable to the doctor as payment toward the total charges for professional services rendered. This payment will not exceed my indebtedness to the assignee. I agree that a photocopy of this agreement shall serve as the original. I acknowledge I have been offered a copy of this offices HIPPA policies, and I authorize disclosure of my medical records as described In the HIPPA pamphlet.

I understand that payment is expected at the time of service. I choose to pay by (please check √):

____ Cash/Check ____ Credit Card ____ Spouse's Insurance ____ Worker's Comp Insurance ____ Auto Insurance
____ HMO ____ Medicare ____ Medicaid ____ Other _____ ____ General Health Insurance (PPO)

Patient's Signature _____ Date _____/_____/_____
(If you are under 18 years of age, we need a parent or guardian signature authorizing us to treat you.)

Parent/Guardian Signature _____ Date _____/_____/_____