

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 # OF CHILDREN ____

OCCUPATION: _____ EMPLOYED BY: _____

SPOUSE'S NAME: _____ MI _____ EMPLOYED BY: _____

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):

- | | | | | | |
|----------------------|-------------------|-------------------------|----------------|------------------------------|-------------------|
| 1) Sinus | 08) Migraines | 15) Hand/Wrist Pain | 22) Foot Pain | 29) Low Back Pain | 37) Weak Immunity |
| 2) Hip Pain | 09) Jaw - TMJ | 16) Neck Pain | 23) Numbness | 30) Mid Back Pain | 38) Infertility |
| 3) Chest Pain | 10) Asthma | 17) Neck Stiffness | 24) Digestion | 31) Upper Back Pain | 39) Depression |
| 4) Allergies | 11) Arthritis | 18) Tailbone Pain | 25) Headaches | 32) Menstrual problems | |
| 5) Arm Pain | 12) Sciatica | 19) General Health | 26) Bedwetting | 33) Fibromyalgia | |
| 6) Knee Pain | 13) Ulcers | 20) Nervousness/tension | 27) Leg Pain | 34) Chronic Fatigue Syndrome | |
| 7) Chronic Infection | 14) Shoulder Pain | 21) Ankle Pain | 28) Elbow Pain | 36) Other: _____ | |

Other Complaints (please specify): _____

My condition is due to (please circle):

- | | | |
|---------------------|----------------------|-------------|
| 1) Auto Accident | 03) Sports Accident | 05) Unknown |
| 2) 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):

| | | | | |
|-------------------------------------|--------------------------------------|---|--|---|
| <input type="checkbox"/> Cash/Check | <input type="checkbox"/> Credit Card | <input type="checkbox"/> Spouse's Insurance | <input type="checkbox"/> Worker's Comp Insurance | <input type="checkbox"/> Auto Insurance |
| <input type="checkbox"/> HMO | <input type="checkbox"/> Medicare | <input type="checkbox"/> Medicaid | <input type="checkbox"/> Other _____ | <input type="checkbox"/> 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** ____/____/____