Chiropractic Offices of CACHE VALLEY

Welcomes You!

ABOUT YOU

Today's Date: ____/____/____

Patient's Name: _____ What do you prefer to be called: _____
LAST FIRST MI

Birth date: ____/____/____ Age: _____ Height: _____ Weight: _____ ❑ Male ❑ Female SS#: ____-____- _____

Status: ❑ Minor ❑ Single ❑ Married ❑ Divorced ❑ Separated ❑ Widowed Spouse's Name: _____

Mailing Address: _____
STREET CITY STATE ZIP

Phone#:_____ Cell#:_____

Email: _____ Occupation: _____ Employer: _____

Refered by: _____ Are you insured? ❑ YES ❑ NO Company: _____

Insured's Name: _____ SS#: ____- ____ - _____

Nearest Relative not living with you: _____ _____
Name Phone

REASON FOR VISIT

The reason for this visit is a result of (please circle) : Work Sports Auto Trauma Chronic

Explain what happened: _____

Major Complaint: _____

When did the condition begin: ____/____/____ Is the condition getting worse? ❑ YES ❑ NO ❑ Constant ❑ Comes and goes

Is this condition interfering with your (please circle) : Work Sleep Daily Routine

Have you had this or similar conditions in the past? ❑ YES ❑ NO If so, please explain: _____

_____

Have you been treated by a Medical Physician for this condition? ❑ YES ❑ NO

Have you been treated by a Chiropractor before? ❑ YES ❑ NO

HEALTH HISTORY

Are you taking any medications? ❑ YES ❑ NO If yes, please list: _____

Please list any serious medical condition(s) you have ever had: _____

Please list anything you may be allergic to: _____

List previous surgeries with dates: _____

List any past serious accidents with dates: _____

Family health history: _____

Do you take supplements or vitamins? ❑ YES ❑ NO Exercise? ❑ YES ❑ NO

For Women: Are you taking Birth Control: ❑ YES ❑ NO Are you pregnant? ❑ YES ❑ NO If yes, how long:____ Nursing? ❑ YES ❑ NO

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. I assign and authorize payment directly to Chiropractic Offices of any insurance benefits that I may have payable to me, and understand that these funds will be credited to my account(s) upon receipt. I also give Chiropractic Offices power of attorney to endorse checks made out to me, to be credited to my account(s). Furthermore, I clearly understand and agree that I am personally responsible for payment of any and all charges for services rendered. If payment is not fully satisfied or financial arrangements agreed to by Chiropractic Offices, I agree to pay all costs to collect the debt, including, but not limited to interest in the amount of 18% per annum, attorney's fees, court costs, and collection fees in the amount of 40%. The obligation to pay the collection fees shall be imposed at the time of assignment of the debt to a third party debt collection agency. As with any medical procedures, there are inherent risks that can occur. Although these risks are not highly prevalent in the administration of chiropractic care, they are nevertheless present. If I have any concerns in this regard it is my responsibility to discuss them with the doctor. By signing below, I acknowledge that I have received satisfactory informed consent for any and all procedures performed by Chiropractic Offices.

Signature _____ **Date** ____/____/____