Application of Care

The following information is needed to better serve you. Please complete all questions. If you need help, please ask the receptionist. PLEASE PRINT.

Today's Date _____

Name _____ Home Phone _____ Work Phone _____

Cell Phone _____ E-Mail Address _____

Address _____ City _____ State _____ Zip _____

Age _____ Date of Birth _____ Marital Status: S M W D Number of Children _____

Please circle one payment method: Cash Check Master/Visa Card American Express

Your Employer _____ Occupation _____ Years on Job _____

Employer Address _____ City _____ State _____ Zip _____

Insurance Company _____ Social Security # _____

Do you have Medicare? Yes _____ No _____ Do you have Medicaid? Yes _____ No _____

Name of Spouse or Parent _____ Their Date of Birth _____

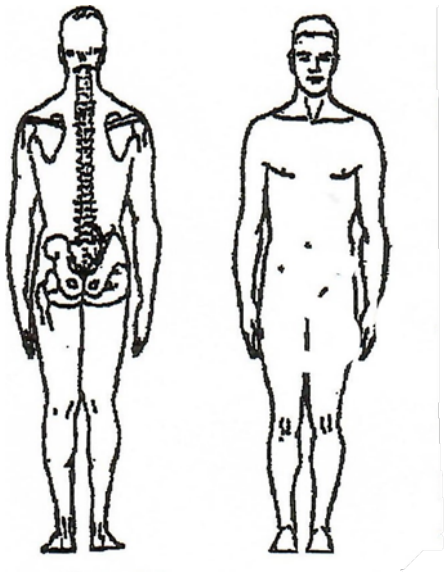
Spouse Employed by _____ Occupation _____ Year On Job _____

Employer Address _____ City _____ State _____ Zip _____

Office Phone # _____ Spouse's SS # _____

Driver's License # _____

Does your spouse have health insurance at work? Yes _____ No _____



Insurance Policy00

COMPLETE THESE DIAGRAMS

If you are in pain, please mark the exact location of your pain on the diagram. Also describe the type and frequency of your pain, as well as any activity which brings on or aggravates the pain. For example, dull, sharp, consistent, off & on, when standing, when sitting, etc.

MAJOR COMPLAINTS

(Please list any condition you are being treated for or are experiencing)

_____

_____

_____

Referred to our office by: _____

How payment will be made:

Cash _____ Workers Comp _____

Check _____ Credit Card _____

Type of Insurance:

Health Insurance _____

Automobile _____

Is your condition due to an accident? Yes _____ No _____ Date of accident? _____

Type of accident? Auto _____ Work/On Job _____ At Home _____ Other _____

Have you ever been in an auto accident? Past Year _____ Past 5 Years _____ Over 5 Years _____ Never _____

I (we) agree to pay for services rendered to the above-mentioned patient as the charge is incurred. I understand and agree that health & accident insurance policies are an arrangement between an insurance carrier and myself and that I am personally responsible for payment of professional services rendered to me will be immediately due and payable.

Patient Signature _____ Date _____

Notice to our new patients: Full payments for services rendered is due at the end of each visit. If for any reason this request cannot be met, arrangements should be made in advance before seeing the doctor.

Insurance cases: On all insurance assignments, the deductible should be met in the beginning unless prior arrangements are made.

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Or Guardian Signature _____ Date _____

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