Application for Treatment Form

Appointment Date: ______________________________ S.S.# ______________________________________

Name: ______________________________________ Date of Birth: _______________________________

Address: ____

City: _________________________________ State: _____________ Zip: ______________

Home Phone: ______________________ Work/Cell Phone (best way to reach you): _____________________

E-Mail Address: ____

Name of Employer_________________________________ Occupation _________________________________

Name of Spouse ___________________________________ Spouse's Occupation _________________________

In case of emergency, contact ____

Majors Symptoms____

____

How did this condition develop? ____

When were you first aware of this problem? ____

Have you lost any time from work as a result of this problem? ____

Have you been treated for this condition? ______ If yes, when & where? ______________________________

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Have you ever had this problem or similar problem before? ____

If yes, please explain ____

List all surgeries & major illnesses ____

Are you pregnant? _____________ If yes, when is your due date? _______________________________________

List present medications and supplements ____

____

Have you ever received chiropractic treatment? ________ If yes, please describe _________________________

____

How will you be paying for your visits? ____

Insurance Information

Insurance Company: ________________________________ Phone: _______________________________

Mailing Address: ____

Insured Name: ___________________________________ Relationship: _________________________

ID#: ________________________________ Group#: _______________________________________

In Network: Yes/No Effective Date: ____

Deductible: _____________________ Met for Year: __________________ Co-pay: _________________

I understand and agree that health and accident policies are an arrangement between an insurance carrier and myself. I also understand that this office will prepare any necessary forms to assist me in making collection from my primary insurance company and that any amount authorized to be paid should be paid directly to this office and 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 this office DOES NOT bill secondary insurance and that I will be responsible for payments not covered by my primary insurance.

All charges not paid within 90 days will automatically be put through on my credit card unless prior arrangements have been made.

Patient's Signature ____ Date _________________