GENERAL PATIENT INFORMATION:

Name _____
(Last) (First) (M.I.)
Home Address _____ City _____State _____Zip _____
Home Phone _____ Work Phone_____ Cell Phone _____
D.O.B. _____ S.S. # (optional) _____ Age_____
Sex: M F Single ____ Married ____ Divorced ____ Other ____
Name of spouse _____ Ages of Children_____
Email_____ (will not be given out; only to keep you posted on in office activities)

Employer _____ Work Phone _____Ext._____
Work Address_____ City _____State _____
Zip _____

COMPLAINT AND HISTORY:

Reason for coming in today? _____
How long has this condition persisted/when did it begin?_____
Is the condition getting worse? ڤYes ڤ No ڤ Constant ڤ Comes and goes
Have you received medical treatment for this condition? ڤYes ڤ No
Have you received Chiropractic Care for this condition? ڤYes ڤNo
Who referred you? _____Medical Doctor_____
If you were not referred, how did you hear about us? _____

PAYMENT AND INSURANCE INFORMATION:

ڤ Cash ڤCheck ڤCredit Card ڤ Other _____
Do you have health insurance? ڤYes ڤNo
If you checked yes, please give your card to the staff so we can make a copy for our records and billing purposes.
Insurance Company Name_____
Insured Name _____
(Person whose name your insurance coverage is under) (Last) (First) (M.I.)
Your relationship to insured (if you are not policy owner) _____
Insured Address (*if same as above leave blank*)
_____ City _____State _____Zip _____
Home Phone _____ Insured S.S. # _____ Insured D.O.B. _____

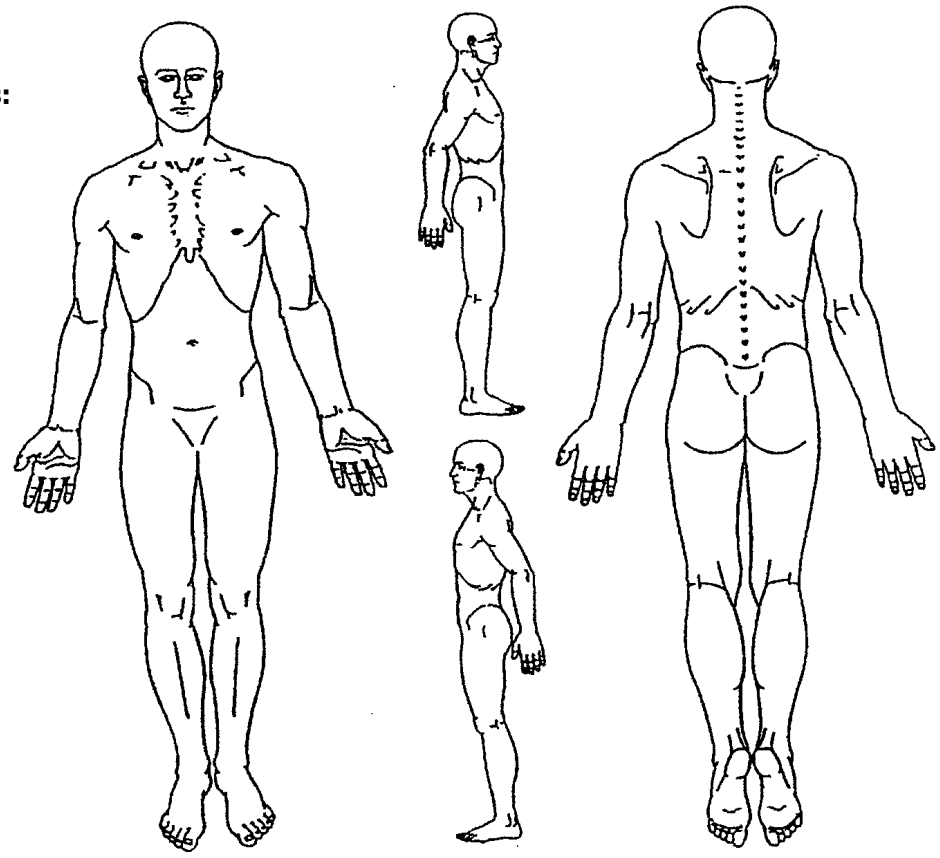
Financial And Treatment Disclaimer PLEASE READ: <u>Our policy requires payments in full for all services rendered at the time of visit</u>, unless other arrangements have been made with the doctor or staff. If the account is not paid in full within 90 days of the date of service and no arrangements have been made, you will be responsible for legal fees, collection agency fees and any other expenses incurred in collecting your account. I authorize the staff to perform any necessary services needed during the diagnosis and treatment. I also authorize the provider and or managed care organization to release any information required to process insurance claims. I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes to the information I have provided.

Signature _____ Date _____
If a minor, guardian's signature _____

Office Use Only: :
LYTEC _____
ROUTING SLIP _____
NEW PATIENT LETTER_____
INSURANCE VERIFIED _____

Your Name_____
Today's Date_____

Mark the body areas that are causing your pain using the following symbols:
A = Ache
B = Burning Sensation
S = Stabbing
N = Numbness
P = Pins & Needles
HA = Headache
O = Other briefly describe



Pain Scale

Circle the number that best describes your pain

1 2 3 4 5 6 7 8 9 10

None Little Medium Severe

Brief Health History Past 10 Years

Recent Illness_____
_____
Past Hospitalizations_____
_____
Past Surgeries_____
_____
Other Major Illness_____
_____
Medications_____
_____

The above information is truthful and accurate.

SIGNATURE_____

if a minor, parent or guardian's SIGNATURE_____