

PATIENT INFORMATION

First Name: _____ Last Name: _____

Birth Date: _____ Age: _____

Address: _____

City: _____ State: _____

Email: _____ Cell Phone: _____ ZIP _____

Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Widowed ☐ Other _____

Occupation: _____ Employer: _____

Employer Address: _____ Employer Phone: _____

Name of Nearest Relative: _____ Address: _____

Relative's Phone #: _____

INSURANCE INFORMATION

Please check all insurance coverage that may be applicable in this case:

☐ Major Medical ☐ Worker's Compensation ☐ Other _____☐ Medicare ☐ Auto Accident

Name of Insurance Company: _____ State: _____

Policy Holder Name: _____ Birth Date: _____

Member ID: _____ Group: _____

Name of Employer: _____

Relationship to Insurance holder: ☐ Self ☐ Parent ☐ Child ☐ Spouse ☐ Other _____

Name of Secondary Insurance Company: _____ State: _____

Policy Holder Name: _____ Birth Date: _____

Member ID: _____ Group: _____

Name of Employer: _____

Relationship to Insurance holder: ☐ Self ☐ Parent ☐ Child ☐ Spouse ☐ Other _____

AUTHORIZE AND RELEASE: I authorize payment of insurance benefit directly to the chiropractor or chiropractic office. I authorize the doctor to release/obtain all information necessary to communicate with personal physicians and other healthcare providers and payers and to secure the payment of benefits. I understand that I am responsible for all cost of chiropractic care regardless of insurance coverage. I promise to notify McKenzie Chiropractic Clinic if at any time there is a change in my Insurance Policy(s) or Benefits. I expressly guarantee payment of the account/dependent named above and agree to pay any charges left unpaid in whole or in part by the insurance company. I also understand that if I suspend or terminate my schedule of care as determined by my treating doctor any fees for professional services will be immediately due and payable. I understand that interest is charged on overdue accounts at the annual rate of 18%. Cash-Based Treatment Package sales are final and no refunds will be issued. I understand packages do not expire and can only be redeemed at the original location of purchase and that any unused sessions are transferable to family/friends.

The patient understands and agrees to allow this chiropractic office to use their Protected Health Information ("PHI") for the purpose of treatment, payment, healthcare operations, and coordination of care. We want you to know how your PHI is going to be used in this office and your rights concerning those records. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your PHI we encourage you to read the HIPAA NOTICE that is available to you at the front desk before signing this consent. If there is anyone you do not want to receive your medical records, please inform our office.

Patient Signature_____
Date_____
Guardian's Signature Authorizing Care_____
Date



HEALTH INFORMATION

How were you referred to our office? _____

Family Medical Doctor: _____ Phone: _____

Date of last physical examination: _____ Date symptoms appeared: _____

Purpose of this Appointment: _____

Have you had the same or similar condition: Yes ____ No ____ If yes, when and describe: _____

Medications: _____

Serious illnesses / surgeries (include dates): _____

Have you been treated for any health condition by a physician in the last year? Yes: _____ No: _____

If yes, please describe: _____

What is your major symptom? _____

What does this prevent you from doing or enjoying? _____

If this is a recurrence, when was the first time you noticed this problem? _____

How did it originally occur? _____

Please Describe: _____

Has it become worse recently? Yes _____ No _____ Same _____ Better _____ Gradually Worse _____

How frequent is the condition? Constant _____ Daily _____ Intermittent _____ Night Only _____

How long does it last? All Day _____ Few Hours _____ Minutes _____

Are there any other conditions or symptoms that may be related to your major symptom? Yes _____ No _____

If yes, describe: _____

Describe the pain: Sharp _____ Dull _____ Numbness _____ Tingling _____ Aching _____ Burning _____ Stabbing _____ Other: _____

What makes the problem worse: Standing _____ Sitting _____ Lying _____ Bending _____ Lifting _____ Twisting _____

Other, Please Describe: _____

Is there anything that you can do to relieve the problem: Medication _____ Stretching _____ Exercise _____

Laying _____ Resting _____ Sitting _____ Cold _____ Heat _____ Massage _____

What have you tried that has not helped? _____

Have you had any broken bones? Yes _____ No _____ If yes, please list and explain: _____

Do you exercise? Yes _____ No _____ If yes, what forms: _____

Women Only: Are you pregnant or is there any possibility you may be pregnant? Yes _____ No _____ Uncertain _____

Remarks: _____

Please Indicate Your Pain Level Below

No Pain 1 2 3 4 5 6 7 8 9 10 Severe Pain