

Jenkintown Chiropractic Center



New Patient Information

Name _____ Female Male Date _____

What you prefer to be called _____ Age _____ Date of birth _____

Preferred Language English Other _____ Race: White African American Other _____

Address _____ City _____ State _____ Zip _____

Home Phone _____ Cell Phone _____

Email Address _____ SS# _____

Preferred Method of Contact _____

Employer _____ Occupation _____ Work Phone _____

Emergency Contact _____ Relation _____ Phone _____

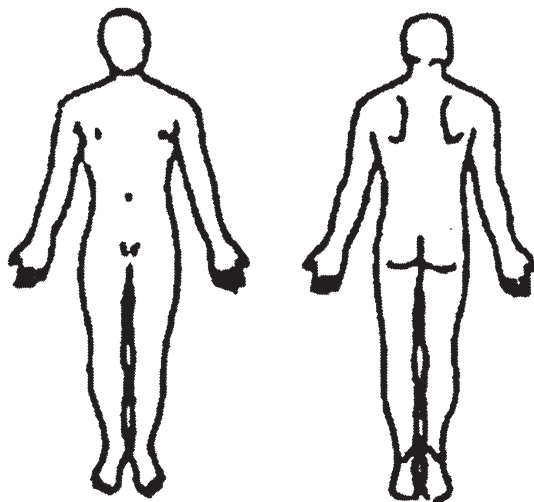
How did you hear about our office? _____

When did your condition begin? _____

Other Doctors seen for this condition? _____

Have you had the same or similar symptoms before? Yes No Date of prior condition _____

Mark Areas of Pain on Figures Below



List chief symptoms in order of severity:

(1) _____

(2) _____

(3) _____

Have you had chiropractic care before? Yes No

Family Physician _____

May we forward our findings to your doctor? Yes No

Current Medications _____

Allergies (Medicine, Food, Environment) _____

Previous Surgeries _____

Do you have a PERSONAL history of: Cancer Diabetes Heart Disease Stroke

Other serious illnesses _____

Check all symptoms that apply to you:

- | | | | |
|--|--|-------------------------------------|--|
| <input type="checkbox"/> Headache | <input type="checkbox"/> Tingling/numbness in arms/hands | <input type="checkbox"/> Chest Pain | <input type="checkbox"/> Unexplained weight loss |
| <input type="checkbox"/> Neck Pain/Stiffness | <input type="checkbox"/> Tingling/numbness in legs/toes | <input type="checkbox"/> Knee Pain | <input type="checkbox"/> Fatigue |
| <input type="checkbox"/> Back Pain/Stiffness | <input type="checkbox"/> Loss of balance/dizziness | <input type="checkbox"/> Hip Pain | <input type="checkbox"/> Night Sweats |
| <input type="checkbox"/> Shoulder Pain | <input type="checkbox"/> Shortness of breath | <input type="checkbox"/> Fever | <input type="checkbox"/> Blood in Urine |
| <input type="checkbox"/> Other _____ | | <input type="checkbox"/> Night Pain | <input type="checkbox"/> Pain unrelieved by rest |

For women: Are you pregnant? Yes No

Are you taking birth control? Yes No

Health Insurance

Policyholder Name _____ Date of Birth _____

Workers Compensation

Is your condition due to an Employment Related Injury? Yes No Have you reported it? Yes No

Date of accident _____

Supervisor _____ Supervisor # _____

Auto Accident

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

Auto Accident Insurance Name _____ Claim # _____

Adjuster Name _____ Phone # _____

Attorney Name _____ Phone # _____

INSURANCE INFORMATION, CONSENT OF PROFESSIONAL SERVICES AND RELEASE OF INFORMATION

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore I understand that this office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to this office will be credited to my account on 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 if I suspend or terminate my care and treatment, any fees for professional services rendered to me will be immediately due and payable.

I hereby authorize the doctors and their affiliated providers to administer treatment, physical examination, X-ray studies, laboratory procedures, chiropractic care, physical therapy, or any clinic services that they deem necessary in my case; I do hereby give my consent for the performance of conservative non-surgical treatment, including, but not limited to manipulation, physical therapy modalities, soft tissue massage and therapeutic exercises. I am aware there are possible risks and complications associated with these procedures, ranging from soreness to stroke. I understand there is no certainty that I will achieve benefits and acknowledge that no guarantee has been made regarding the outcome of these procedures. I am aware there are alternatives to these procedures, including medication and/or surgery. In order to ensure that all of my healthcare providers function as a team, I hereby grant the providers and clinical staff of this clinic to communicate with and relay any information about my condition to my other healthcare providers. I further authorize them to disclose all or any part of my (patient's) record to any person or corporation which is or may be liable under a contract to the clinic or to the patient or a family member or employer of the patient for all or part of the clinic's charge, including, and not limited to hospital or medical services companies, insurance companies, workers compensation carriers, welfare funds, or the patient's employer. I understand that if an insurance company initially pays for my treatment and later requests reimbursement from this clinic for any reason, I will be responsible for payment of my entire outstanding balance.

We invite you to discuss any questions you might have with us. The best health services are based on a friendly mutually understood relationship.

Patient's or Guardian's Signature _____ Date _____

CONSENT TO TREAT A MINOR

I (we) being the parent, guardian or custodian of the minor being _____, age _____, do hereby authorize, request & direct this clinic, it's doctors and staff to perform examinations, diagnostic x-rays, laboratory tests, and any treatment that in their judgment, is deemed advisable or required.

It is the understanding of the undersigned that the physicians and their staff will have full authority from me as legal parent/guardian to continue with examinations, diagnostic tests, and treatments as will be needed while said minor shown above is under care in this office until legal age is attained.

As legal parent/guardian, I realize full responsibility for all charges and payments due.

Parent/Guardian or Custodian Signature _____

Date Signed _____

Witness _____