

**INFORMATION/APPLICATION FOR CARE**

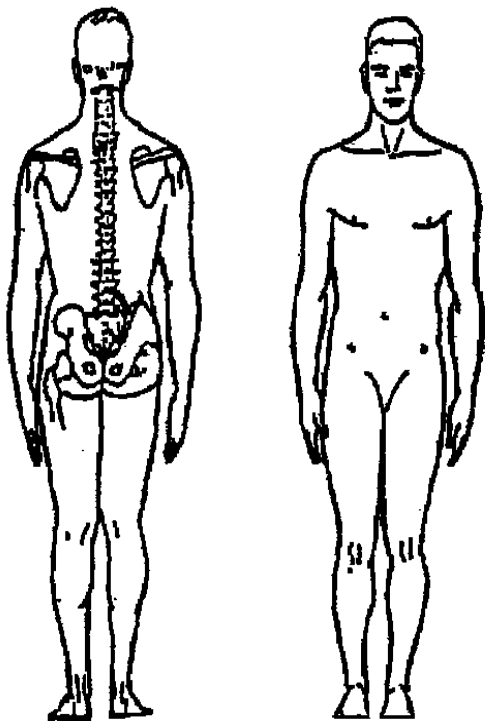
The following information is needed in order to better serve you. Please complete all questions. If you need help please ask the receptionist. (PLEASE PRINT.)

Name \_\_\_\_\_ Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_ Today's Date \_\_\_\_\_  
 Cell Phone \_\_\_\_\_ E-Mail Address \_\_\_\_\_  
 Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
 Age \_\_\_\_\_ Birth date \_\_\_\_\_ Marital Status: S M W D Number of Children \_\_\_\_\_

Please circle one payment type: Cash Check Master Card/Visa American Express  
 Your Employer \_\_\_\_\_ Occupation \_\_\_\_\_ Years On Job \_\_\_\_\_  
 Employer Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
 Insurance Company \_\_\_\_\_ Your Social Security # \_\_\_\_\_  
 Do you have Medicare? Yes \_\_\_ No \_\_\_ Do you have Medicaid? Yes \_\_\_ No \_\_\_  
 Name of Spouse or Parent \_\_\_\_\_ Their Birthdate \_\_\_\_\_  
 Spouse Employed By \_\_\_\_\_ Occupation \_\_\_\_\_ Years 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 \_\_\_

**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: \_\_\_\_\_ Type of Insurance: \_\_\_\_\_  
 \_\_\_\_\_ Cash \_\_\_\_\_ Worker's Comp. \_\_\_\_\_ Health Insurance  
 \_\_\_\_\_ Check \_\_\_\_\_ Credit Card \_\_\_\_\_ Automobile Insurance Policy

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 any and all services covered or not covered. I also understand that if I suspend or terminate my care and treatment, any fee for professional services rendered me will be immediately due and payable.

Patient's Signature \_\_\_\_\_ Date \_\_\_\_\_  
Or Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_

Notice to our new patients: Full payment 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.