CARR CHIROPRACTIC CLINIC

INFORMATION/APPLICATION FOR CARE

OFFICE USE ONLY
Patient No.:_____
Date: _____

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)**

First Name_____ M.I. ___ Last Name _____ Sex: M F

Home Phone _____ Work Phone _____ Cell Phone _____

E-Mail Address _____

Address _____ City _____ State _____ Zip _____

Birth date _____ Age _____ Marital Status: S M W D Number of Children _____

Driver's License # _____ Social Security # _____

Your Employer _____ Occupation _____Years On Job ____

Employer Address _____ City _____ State _____ Zip _____

Do you have Medicare? Yes ____ No ____ Do you have Medicaid? Yes ____ No ____

Insurance Company _____ Insured's Name: _____

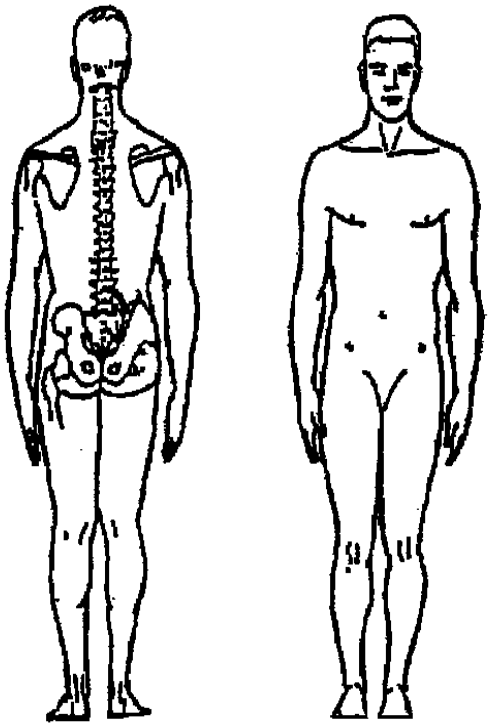
Relationship: _____ Insured's Birth date: _____ Insured's SS#: _____

Insured Employed By: _____ Occupation: _____

Employer Address _____ City _____ State _____

Zip _____ Office Phone # _____ Years On Job _____

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, constant, off & on, when standing, when sitting, etc……

MAJOR COMPLAINTS

(Please list any condition you are being treated for or are experiencing.)

_____
_____
_____
_____
_____
_____
_____
_____

(TURN OVER)

CARR CHIROPRACTIC CLINIC

Whom may we thank for referring you to our office?
_____

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.

Authorization for email communication

Printed Name: _____ **Date:** _____

Printed Email address: _____

Signature: _____

Please be aware that you can opt out for email communication at any time.

(TURN OVER)