Preferred Chiropractic

3985 N. Michigan Ave. Saginaw, MI 48604

Please complete this form. Your answers will help us determine if chiropractic can help you. If we do not sincerely believe that your condition will respond satisfactorily, we will not accept your case. Thank You.

General Information

Last Name ______________________ First Name ______________________ Middle Intitial ______

Address ______________________ City ______________ State ________ Zip ____________

Home Phone ( ) ______________________ Work Phone ( ) ______________________ Ext. __________

Cell Phone ( ) ______________________ E-mail Address ______________________

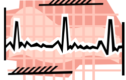
What do you prefer to be called? ______________ **How were you referred to us?** ______________

Employer/Occupation ______________________ Hours you usually work: ______ to ______ Okay to call work**? Y N**

Sex: M ____ F ____ Birth date: _____ / _____ / _________ Age: ____ Social Security Number: _______ - _____ - __________

Marital Status: M S W D Spouse's Name ______________________ Number of Children ____

Have you ever seen a Chiropractor before**? Y N** If Yes, Who and When**?** ______________________



Health Information

Is your condition the result of an Auto Accident**? Y N** Is your condition the result of a Work related injury**? Y N**

Have you <u>EVER</u> been in <u>ANY KIND</u> of Auto Accident? Y N If Yes, When? Past Year ___ Past 5 yrs ___ Over 5 yrs ___

Describe: ______________________

What is your major complaint**?** ______________________ Other complaints**?** ______________________

How long have you had this condition**?** ______________________ Have you had similar conditions in the past**? Y N**

What areas of your life have been affected by your pain and symptoms**?** ______________________

____

What activities aggravate your condition**?** ______________________

Is your condition: Getting progressively worse**? Y N** Constant**? Y N** Does it Come and Go**? Y N**

Is your condition interfering with: Work**? Y N** Sleep**? Y N** Daily routine**? Y N** Other ______________

How long has it been since you felt good**?** ____________ Have any other Doctors treated you for this condition**? Y N**

If Yes, Who and When**?** ______________________

List all surgical operations and years ______________________

Drugs you are taking: Nerve Pills ____ Pain Killers ____ Muscle Relaxers ____ Tranquilizers ____ Anti-Depressants ____

Birth Control ____ Others______________________ How old is your Mattress**?** ____________ Is it Comfortable**? Y N**

Do you wear: Heel lifts**? Y N** Sole lifts**? Y N** Arch supports**? Y N** Other ______________

For Women: Are you pregnant**? Y N** If Yes, how far along**?** ______________ Are you Nursing**? Y N**

Patient's Primary Care Physician: ______________________

Address: ______________________Phone Number: ______________

I guarantee that this form was completed correctly to the best of my knowledge. I authorize the Doctors and/or staff at Preferred Chiropractic to perform any services necessary during my diagnosis and treatment. I understand that it is my responsibility to inform this office of any changes to the information I have provided.

Signature ______________________ Date ______________

☐ Adult Patient ☐ Parent or Legal Guardian ☐ Spouse

Patient Information Form

I, ____ , hereby authorize assignment of my insurance rights and benefits directly to the provider for services rendered. I understand and agree that health and accident policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that this Chiropractic Office will prepare any necessary reports and forms to assist me in making collections from the insurance company, and that any amount authorized to be paid directly to this Chiropractic Office will be credited to my account upon receipt. However, I fully understand that I am solely responsible for any balance not paid for by my insurance company, and that if my insurance carrier does not cover the charge for any treatment, claiming that the treatment was not “medically necessary”, then I understand and agree that I will be responsible for the cost of the treatment provided. 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 understand that I am responsible for any and all additional fees that are incurred in an effort to collect on my past due account (including legal fees, collection agency fees, interest, etc). I also understand that if I suspend or terminate my care and treatment, any unpaid fees for professional services rendered to me will be immediately due and payable.

Signature ____ Date ___________________________________

□ Adult Patient □ Parent or Legal Guardian □ Spouse

IF YOUR CONDITION IS NOT related to an Auto Accident/Work related/Personal injury, please sign and date below.

Auto Accident/Work Related/Personal Injury Waiver

I, ____ , guarantee that the treatment that I am about to receive at Preferred Chiropractic is not in any way the result of an Auto Accident, Work related injury, or Personal injury.

Signature ____ Date ___________________________________

□ Adult Patient □ Parent or Legal Guardian □ Spouse