

Preferred Chiropractic of Shields

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 Initial _____

Address _____ City _____ State _____ Zip _____

Home Phone () _____ Work Phone () _____ Ext. _____

Cell Phone () _____ E-mail Address _____

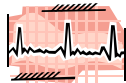
What do you prefer to be called? _____ **How were you referred to us?** _____

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 EVER been in ANY KIND 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**

I guarantee that this form was completed correctly to the best of my knowledge. I authorize the Doctors and/or staff at Shields 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

If you have health insurance that is paying for some or all of your care in our office, please read the following information and sign and date below.

Insurance Assignment

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 Shields 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
