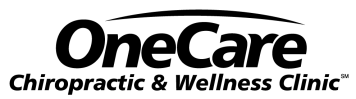
**Dr. David N. Jacobsen Dr. Jaime Perez**  755 Westmoreland Rd. Daytona Beach, Florida 32114

4865 Palm Coast Parkway N.W. Suite 1, Palm Coast, FL 32137

(386) 226-0011 fax (386) 226-0013

PERSONAL INFORMATION

Last Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_First Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Middle Int: \_\_\_\_\_\_\_

Birthdate: \_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_ ❑ Male ❑ Female

Mailing Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_\_\_\_\_\_

Mobile Phone: (\_\_\_\_\_\_\_\_\_\_) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Home Phone: ( \_\_\_\_\_\_\_\_\_\_) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

EMERGENCY INFORMATION

Name you wish on file: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: (\_\_\_\_\_\_\_\_) \_\_\_\_\_\_\_\_\_\_-\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

REASON FOR TODAY’S VISIT

The reason for this visit is: ❑ Sports injury ❑ Auto Accident ❑ Work Injury ❑ Motorcycle ❑ Wellness Visit

If injury, briefly explain what happened: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

When did the condition begin? \_\_\_\_\_\_\_/\_\_\_\_\_\_\_/\_\_\_\_\_\_\_ Status: ❑ Staying the same ❑ Getting worse ❑ Improving

Have you been to the Hospital or ER for this? ❑ No ❑ Yes Where? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you been to a medical doctor for these complaints? ❑ No ❑ Yes Who? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Any previous Chiropractic care? ❑ No ❑ Yes If yes, who? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Have you received any recent X-rays, MRI’s or other tests? ❑ No ❑ Yes \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

HEALTH HISTORY

List Medications currently taking or have a prescription for:

1. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_for \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 6. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ for \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

2. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_for \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 7. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ for \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

3. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_for \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 8. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ for \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

4. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_for \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 9. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ for \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

5. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_for \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 10. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ for \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Check if you HAD or Now have any of the following conditions:

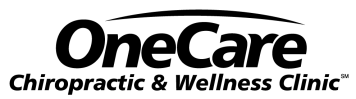
|  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Had | Now | Condition |  | Had | Now | Condition |  | Had | Now | Condition |
|  |  | Aids/HIV |  |  |  | Alcoholism |  |  |  | Allergies |
|  |  | Anemia |  |  |  | Anxiety |  |  |  | Arteriosclerosis |
|  |  | Arthritis |  |  |  | Asthma |  |  |  | Cancer |
|  |  | COPD |  |  |  | Crohn’s Disease |  |  |  | Depression |
|  |  | Diabetes |  |  |  | Dizziness/Vertigo |  |  |  | Emphysema |
|  |  | Fainting Spells |  |  |  | Glaucoma |  |  |  | Goiter |
|  |  | Gout |  |  |  | Heart Attack |  |  |  | Heart Disease / Murmur |
|  |  | Hepatitis |  |  |  | High Blood Pressure |  |  |  | Lupus |
|  |  | Malaria |  |  |  | Measles |  |  |  | Migraines |
|  |  | Mitral Valve prolapse |  |  |  | Multiple Sclerosis |  |  |  | Mumps |
|  |  | Numbness |  |  |  | Osteoporosis / Osteopenia |  |  |  | Parkinson’s |
|  |  | Pins & Needles sensation |  |  |  | Polio |  |  |  | Rheumatic fever |
|  |  | Scarlet fever |  |  |  | Shingles |  |  |  | Stroke |
|  |  | Tuberculosis |  |  |  | Typhoid fever |  |  |  | Ulcer(s) |

***Check if you have experienced any of the following recently:***

❑ Surgery ❑ Fever/chills ❑ Night pain waking you up ❑ Loss of bladder or bowel control

❑ Any Infections needing antibiotics ❑ Unexplained Weight Loss ❑ Seizures/Fainting

Patient Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ NP1

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SURGERY: ❑ NONE or Put YEAR of surgery next to those checked:

❑ Spine \_\_\_\_\_\_\_\_\_\_ ❑ Cancer \_\_\_\_\_\_\_\_\_ ❑ Knee (R/L) \_\_\_\_\_\_\_\_\_\_ ❑ Shoulder (R/L) \_\_\_\_\_\_\_\_\_\_ ❑ Wrist (R/L) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

❑ Heart \_\_\_\_\_\_\_\_\_\_ ❑ Kidney \_\_\_\_\_\_\_\_\_\_ ❑ Tonsils \_\_\_\_\_\_\_\_\_\_ ❑ Hip (R / L ) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ❑ Carotid Artery \_\_\_\_\_\_\_\_\_\_\_\_

❑ Adenoids \_\_\_\_\_\_\_\_\_ ❑ Gallbladder \_\_\_\_\_\_\_\_\_\_ ❑ Cosmetic \_\_\_\_\_\_\_\_\_ ❑ Eye \_\_\_\_\_\_\_\_\_\_ ❑ Tonsillectomy \_\_\_\_\_\_\_\_\_\_\_\_\_

❑ Appendix \_\_\_\_\_\_\_\_\_ ❑ Pacemaker \_\_\_\_\_\_\_\_\_\_ ❑ Stent(s) ❑ Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Female: ❑ Hysterectomy \_\_\_\_\_\_\_\_\_\_ ❑ C-Section \_\_\_\_\_\_\_\_\_\_\_\_\_ ❑ Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Male: ❑ Prostrate \_\_\_\_\_\_\_\_\_\_ ❑ Testicular \_\_\_\_\_\_\_\_\_\_\_\_ ❑ Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

ALLERGIES:

To Medications: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

To Environment: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

FAMILY HISTORY:

|  |  |  |  |
| --- | --- | --- | --- |
| Relative | Age (if living) | Age (if passed) | Health Conditions |
| Mother |  |  |  |
| Father |  |  |  |
| Sister 1 |  |  |  |
| Sister 2 |  |  |  |
| Brother 1 |  |  |  |
| Brother 2 |  |  |  |
|  |  |  |  |

SOCIAL: Your Current Age: \_\_\_\_\_\_\_\_ Are you: ❑ Right handed ❑ Left handed ❑ Ambidextrous

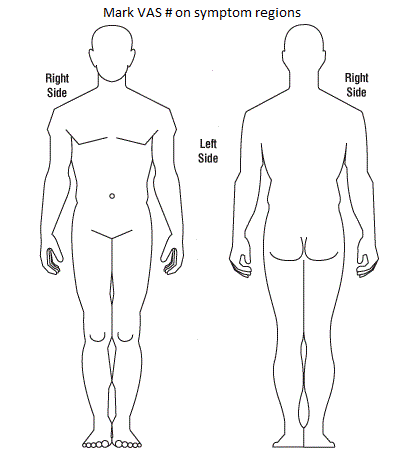
Status: ❑ Minor ❑ Single ❑ Married ❑ Separated ❑ Divorced ❑ Widowed Number of Children: \_\_\_\_\_\_\_\_\_\_

Tobacco: ❑ Never ❑ Up to 10 cigarettes/day ❑ 10-20 cigarettes/day ❑ > 20 per day How long? \_\_\_\_\_\_\_ I Quit (when?) \_\_\_\_\_\_\_\_\_\_\_

Alcohol: ❑ Never ❑ Rare/social events ❑ Daily ❑ History of Treatment for Addiction

Exercise: ❑ None ❑ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Vitamins/Supplements/Herbs: ❑ No ❑ Yes \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Soft Drinks per week?\_\_\_\_\_\_\_ Drink Water Daily? \_\_\_\_\_\_\_\_

****

EMPLOYMENT INFORMATION

❑ I am not currently employed ❑ I am a stay at home caretaker

Employer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Occupation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ How Long? \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Job Duties: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you missed work as a result of your current symptoms? ❑ No ❑ Yes How many days? \_\_\_\_\_\_\_\_ Weeks? \_\_\_\_\_\_\_\_\_

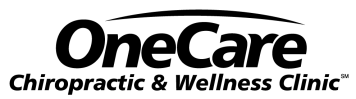
Any Light Duty Available? ❑ No ❑ Yes

PAIN / SYMPTOM LOCATIONS:

Please mark pain areas on the body diagrams:

|  |
| --- |
| Doctors Notes: |
|  |
|  |
|  |
|  |
|  |
|  |
|  |
|  |

Patient Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ NP2

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Activities of Daily Living (ADL)

|  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Activity | No  Effect | Mild  Effect | Moderate  Effect | Severe  Effect |  | Activity | No  Effect | Mild  Effect | Moderate  Effect | Severe  Effect |
| Sitting |  |  |  |  |  | Grocery Shopping |  |  |  |  |
| Rising out of chair |  |  |  |  |  | Household Chores |  |  |  |  |
| Standing |  |  |  |  |  | Lifting Objects |  |  |  |  |
| Walking |  |  |  |  |  | Reaching Overhead |  |  |  |  |
| Lying down |  |  |  |  |  | Showering or bathing |  |  |  |  |
| Bending over |  |  |  |  |  | Dressing self |  |  |  |  |
| Climbing stairs |  |  |  |  |  | Getting to sleep |  |  |  |  |
| Using a computer |  |  |  |  |  | Staying asleep |  |  |  |  |
| Getting in/out of car |  |  |  |  |  | Concentrating |  |  |  |  |
| Driving a car |  |  |  |  |  | Exercising |  |  |  |  |
| Looking over shoulders |  |  |  |  |  | Yard Work |  |  |  |  |

What are your Hobbies or activities?

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

FINANCIAL INFORMATION

❑ Please check here if you have this information on a card that we can copy today.

Insurance Company: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: (\_\_\_\_\_\_\_) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State: \_\_\_\_\_\_\_ Zip: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Insured’s ID#: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Group/Plan/Policy#: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Insured’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Birth: \_\_\_\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Insured’s Employer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\*Please inform the staff of any secondary insurance.

ACCOUNT INFORMATION (Person or entity ultimately responsible for account)

❑ Same as Personal Information above on page 1.

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Phone (\_\_\_\_\_\_\_) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State: \_\_\_\_\_\_\_ Zip: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Payment Method (co-pays or outstanding balance after Insurance has paid): ❑ Cash ❑ Check ❑ Credit Card

We invite you to discuss with us any questions regarding our services. The best health services are based on a friendly, mutual understanding between provider and patient.

* Our policy requires payment in full for all services rendered at the time of visit, unless other arrangements have been made with the business manager. If account remains unpaid within 90 days of the date of service and no financial arrangement have been made, you will be responsible for legal fees, collection agency fees, and any other expenses incurred in collection efforts.
* I authorize the staff to perform any necessary services needed during diagnosis and treatment, upon my approval when the recommendation is made. The doctor/staff will fully explain any tests or procedures in advance.
* I authorize the provider to release any information required to process insurance claims.
* I understand the above information and state that the forms I have completed are correct to the best of my knowledge and understand it is my responsibility to inform this office of any changes to the information I have provided.
* I hereby authorize assignment of my insurance rights and benefits directly to the provider for services rendered. I fully understand I am solely responsible for any balance not paid by my insurance company.

Patient Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ NP3