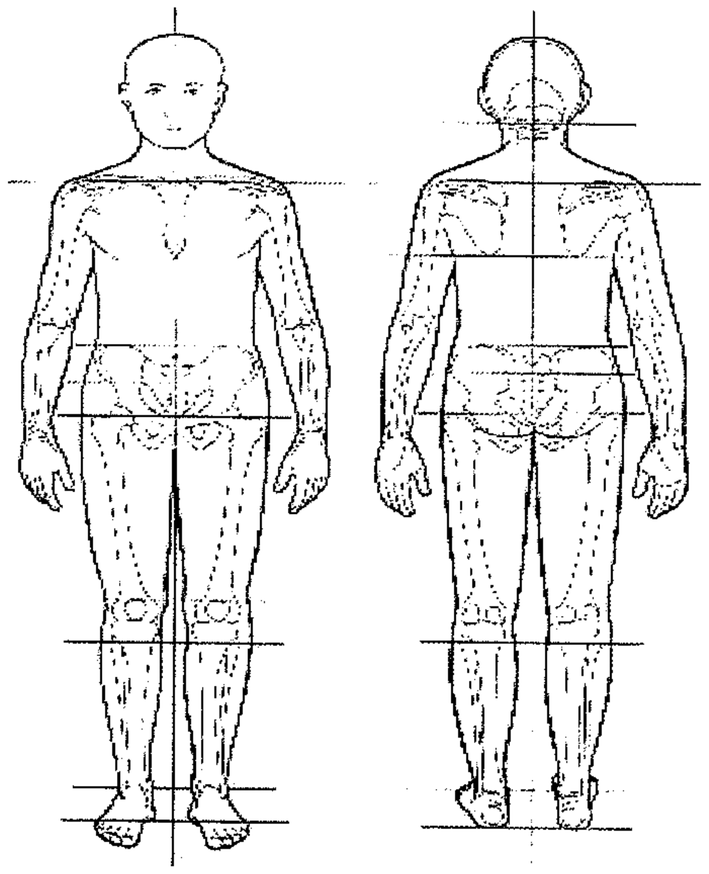
INFORMATION / APPLICATION FOR CARE

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.

Today's Date_____
Name_____ Home Phone_____ Work Phone _____
Cell Phone_____
Address_____ City_____ State_____ Zip_____
Age_____ Birth Date_____ Marital Status: S M W D No. of Children_____
Your Employer_____ Occupation_____ Years on Job____
Employer Address_____ City_____ State_____ Zip_____
Insurance Company_____ Your SS#_____
Do you have Medicare? Yes_____ No_____ Medicaid? Yes_____ No_____
Emergency Contact_____ Phone _____
Spouse Name_____ Birth Date_____
Spouse Employed by_____ City_____ State_____ Zip_____
Work No._____ Does Spouse have health insurance? 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 and on, when standing, when sitting, etc.

MAJOR COMPLAINTS

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

_____
_____
_____
_____
_____
_____

Referred to our office by_____

How payment will be made:

_____Cash _____Check _____Credit Card

Type of Insurance:

Workmen's Comp._____ Health Insurance_____ Auto Ins. Po._____
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_____ 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.

Patients 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.