WELCOME TO ANDERSON HAMO CHIROPRACTIC!

1. PATIENT INFORMATION

Date_____

Patient Name_____

PatientAddress_____

_____

City State Zip

Sex: ___M ___F Age_____

Birthdate:_____

__Single __Married __Widowed __Divorced

__Separated __Minor __Partnered for__yrs

Patient SS#_____

Occupation_____

Employer/School_____

Employer/School Phone_____

Spouse's Name_____

Spouse's Employer_____

Whom may we thank for referring you?

_____

2. PHONE NUMBERS

Home_____

Cell_____

Work_____

Best time and place to reach you:

_____

Email Address_____

IN CASE OF EMERGENCY, CONTACT:

Name_____

Relationship_____

Phone #_____

3. INSURANCE INFORMATION

Person responsible for this account?_____

Relationship to patient? _____

Primary Insurance

Insured's Name_____

Insured's Birthdate_____

Insured's SS#_____

Insurance Co._____

Is patient covered by addit. insurance? ___Y ___N

Secondary Insurance

Secondary Insurance Name_____

Insured's Name_____

Insured's Birthdate_____

Insured's SS#_____

ASSIGNMENT AND RELEASE

I authorize payment of insurance benefits directly to this office. I authorize the doctor to release all information necessary to communicate with other healthcare providers and payors to secure the payment of benefits. I understand that I am responsible for all costs of chiropractic care, regardless of insurance coverage. I understand if I suspend or terminate my schedule of care as determined by my treating doctor, all fees for professional services will be due immediately. Balances over 30 days will be subject to interest charges of 1.5% a month. Original x-rays will remain the property of Anderson Hamo Chiropractic.

_____

Responsible Party Signature Date

4. ACCIDENT INFORMATION

Is condition due to an accident? ____Y ____N

Type of accident ___Auto ___Work ___Home __Other

Date of Accident_____

Attorney Name (if applicable)

_____

5. HEALTH HISTORY

Name _____

Are you pregnant? ____Yes ____No Due Date:_____

Please circle any of the following you have experienced:

Allergies	Cancer	Earaches	Heart Disease	Osteoporosis	Sinus Trouble
Arthritis	Diabetes	Fractures	High BP	Pacemaker	Stroke
Asthma	Digestive Problems	Herniated/Bulged Disc	Migraines	Pinched nerve	

Other_____

Any prior surgeries? _____

Any prior hospitalizations or broken bones?_____

Are you currently being treated by a physician? ____Yes ____No

If Yes, for what?_____

What medications are you taking?_____

6. PATIENT CONDITION

Reason for Visit _____

When did your symptoms appear?_____

Have you experienced this problem before? ____Yes ____No If yes, when did this problem first occur?_____

Is this condition getting progressively worse? ____Yes ____No ____Don't know

How often do you have your symptoms? ___Occasionally ___Frequently ___Constantly

Rate the severity of your pain on a scale of **1 (least pain) to 10 (severe pain)**_____

Type of pain: ___Sharp ___Dull ___Throbbing ___Aching ___Shooting

___Burning ___Tingling ___Numbness ___Stiffness ___Other

Does it interfere with your ___Work ___Sleep ___Daily Activities ___Recreation

What makes the problem worse? __Standing __Sitting __Bending __Twisting __Lying down

Does anything make the problem better? __Yes __No If Yes, what?_____

What treatment have you already received for your condition? ___Medications ___Surgery ___Physical Therapy

___Chiropractic Services ___None ___Other_____

Name of other doctors who have treated you for your condition_____

DOCTOR'S NOTES

_____

_____

_____

_____

_____