CASE HISTORY

PERSONAL INFORMATION

NAME____ DATE__________________
MARITAL STATUS: M W D S
EMPLOYER____ EMP. PHONE _________________
EMP. ADDRESS ____
SPOUSE NAME_____________________________________ SPOUSE DATE OF BIRTH ____________
PERSON RESPONSIBLE FOR THIS ACCOUNT ____
HOW DID YOU HEAR ABOUT OUR OFFICE?____

INSURANCE INFORMATION

WHO IS THE PRIMARY INSURED PERSON? SELF SPOUSE OTHER RELATIONSHIP TO YOU__
IF "OTHER," INDICATE NAME_______________________________________ DOB________________
DO YOU HAVE A HEALTH SAVINGS ACCOUNT (HSA)? YES NO

PLEASE PROVIDE A COPY OF YOUR CURRENT INSURANCE CARD TO THE RECEPTIONIST.

HEALTH BACKGROUND INFORMATION

DOCTORS SEEN FOR THIS CONDITION: MED. DOCTOR _______ CHIROPRACTOR _________
OTHER____
DOCTOR'S NAME_________________________________ DIAGNOSIS ___________________________
PLEASE CIRCLE WHICH TESTS WERE ORDERED: _____ X-RAYS _____ MRI/CT
_____ BLOOD WORK _____ URINALYSIS OTHER: ___________________________________
TREATMENT____

PERSONAL INJURY INFORMATION

LOCATION OF ACCIDENT____ DATE ______________
PLEASE DESCRIBE YOUR INJURIES ____
____
DID YOU GO TO THE HOSPITAL?______ IF SO, WHICH ONE? _________________________________
DATE/TIME OF ADMISSION___________________ DATE/TIME OF RELEASE __________________
ATTORNEY'S NAME & PHONE NUMBER ____
____
INSURANCE CO. NAME & PHONE NUMBER ____
____
CLAIM # _ ____________________________ CONTACT NAME_________________________________

I clearly understand and agree that all services rendered to me are charged directly to me and I am responsible for payment at the time of service. I give my permission for Family Chiropractic & Acupuncture, P.C. to release any of my personal information necessary to receive payment for services from third parties. I understand that there is a $25 charge for any checks written with insufficient funds in my bank account. In the event that I default on my account, I agree to pay interest of 18% per annum after the account is 30 days past due. In the event that my account is forwarded to a collections agency, I agree to pay attorney's fees of 33 1/3% of the total account balance and any other collections fees.

Patient's Signature_____________________________________ Date___________________