Welcome to Advanced Chiropractic Solutions

Patient Information

Thank you for choosing Advanced Chiropractic Solutions for your chiropractic needs. Please complete this form in ink. If you have any questions or concerns, please do not hesitate to ask for assistance. We are happy to help!

(please print clearly)

Name: ____________________ SS/HIC/Patient ID #: ________

First Middle Last

Address: ____________________ City: ________ State: ____ Zip Code: ______

Sex: ❏ Female ❏ Male Birthdate: ________ Email Address: ____________________

Home Phone: (____)________ Cell Phone: (____) ________ Work Phone: (____) ________

Do you prefer to receive calls at: ❏ Home ❏ Work ❏ Cell ❏ No Preference

❏ Married ❏ Widowed ❏ Single ❏ Minor ❏ Separated ❏ Divorced ❏ Partnered for _____ years

Patient Employer/School: ____________________ Occupation: ________

Employer/School Address: ____________________ City: ________ State: ____ Zip Code: ______

Spouse or parent's name: ____________________ Employer: ________ Work Phone: (____) ________

Whom may we thank for referring you to us? ____________________

Have you ever visited our website [URL] before? ____________________

Person to contact in case of emergency: ____________________ Phone: (____)________

Responsible Party

Name of person responsible for this account: ____________________

Relationship to patient: ____________________ Phone: (____)________

Address: ____________________ City: ________ State: ____ Zip Code: ______

Name of employer: ____________________ Work Phone: (____)________

Insurance Information

Name of insured: ____________________ Relationship to Patient: ________

Birthdate: ________ Social Security #: ________ Date Employed: ________

Name of employer: ____________________ Work Phone: (____)________

Address: ____________________ City: ________ State: ____ Zip Code: ______

Insurance Co.:________ Phone: (____) ________ Group #: ______ Employer #: ________

Insurance Co. Address: ____________________ City: ________ State: ____ Zip Code: ______

How much is your deductible? ________ How much have you used? ________ Max. annual benefit? ______

Do you have additional insurance? ❏ Yes ❏ No If "Yes", please complete the following:

Name of insured: ____________________ Relationship to Patient: ________

Birthdate: ________ Social Security #: ________ Date Employed: ________

Name of employer: ____________________ Work Phone: (____)________

Address: ____________________ City: ________ State: ____ Zip Code: ______

Insurance Co.:________ Phone: (____) ________ Group #: ______ Employer #: ________

Insurance Co. Address: ____________________ City: ________ State: ____ Zip Code: ______

How much is your deductible? ________ How much have you used? ________ Max. annual benefit? ______

Symptoms

Reason for the visit: ______________________ When did you first notice the symptoms? ____________

Is the condition getting progressively worse? ____________ Where specifically is the problem(s) located? ____________

Which activities are difficult to perform? ❑ Sitting ❑ Standing ❑ Walking ❑ Bending ❑ Lying down ❑ Other

Type of pain: ❑ Sharp ❑ Dull ❑ Throbbing ❑ Numbness ❑ Aching ❑ Shooting
❑ Burning ❑ Tingling ❑ Cramps ❑ Stiffness ❑ Swelling ❑ Other

Rate the severity of your pain (1 = mild pain or discomfort, to 10 = severe pain) : 1 2 3 4 5 6 7 8 9 10

Is the pain constant or does it come and go? ______________________

What treatment have you received for your condition? ❑ Medication ❑ Surgery ❑ Physical Therapy
❑ Other ______________________

Name and address of other doctor(s) who have treated you for your condition: ______________________

____

Health History *(check only those conditions which are applicable)*

❑ AIDS/HIV	❑ Cataracts	❑ Hepatitis	❑ Osteoporosis	❑ Suicide Attempt
❑ Alcoholism	❑ Chemical Dependency	❑ Hernia	❑ Pacemaker	❑ Thyroid Problems
❑ Allergy Shots	❑ Chicken Pox	❑ Herniated Disc	❑ Parkinson's Disease	❑ Tonsillitis
❑ Anemia	❑ Depression	❑ Herpes	❑ Pinched Nerve	❑ Tuberculosis
❑ Anorexia	❑ Diabetes	❑ High Cholesterol	❑ Pneumonia	❑ Tumors, Growths
❑ Appendicitis	❑ Emphysema	❑ Kidney Disease	❑ Polio	❑ Typhoid Fever
❑ Arthritis	❑ Epilepsy	❑ Liver Disease	❑ Prostate Problems	❑ Ulcers
❑ Asthma	❑ Fractures	❑ Measles	❑ Prosthesis	❑ Vaginal Infections
❑ Bleeding Disorders	❑ Glaucoma	❑ Migraine Headaches	❑ Psychiatric Care	❑ Venereal Disease
❑ Breast Lump	❑ Goiter	❑ Miscarriage	❑ Rheumatoid Arthritis	❑ Whooping Cough
❑ Bronchitis	❑ Gonorrhea	❑ Mononucleosis	❑ Rheumatic Fever	❑ Other ________
❑ Bulimia	❑ Gout	❑ Multiple Sclerosis	❑ Scarlet Fever	________
❑ Cancer	❑ Heart Disease	❑ Mumps	❑ Stroke	________

Dates of last exams: ______________________

List any types of surgeries which you have had and the dates which they occurred: ______________________

____

Please list all medications you are currently taking: ______________________

Allergies: ______________________

Women: Are you pregnant? ❑ Yes ❑ No Nursing? ❑ Yes ❑ No Taking Birth Control Pills? ❑ Yes ❑ No

Daily Habits

What type of exercise do you perform on a daily basis? ❑ None ❑ Moderate ❑ Heavy Description: ____________

What do your daily work habits include? ______________________

What vitamins do you currently take? ____________ Nutritional supplements? ____________

Do you smoke? ❑ Yes ❑ No How much per day? ____________

How much liquor do you consume weekly? ________ How many caffeinated beverages do you consume daily? ________

Certification and Assignment

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if I, or my minor child, ever have a change in health.

I certify that I, and/or my dependent(s), have insurance coverage with and assign directly to Advanced Chiropractic Solutions all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

Advanced Chiropractic Solutions may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

______________________ Signature of Patient, Parent, Guardian or Personal Representative

______________________ Date

______________________ Please print name of Patient, Parent, Guardian or Personal Representative

______________________ Relationship to Patient