******WELCOME******

MASON FAMILY CHIROPRACTIC

PATIENT INFORMATION (please print)

NAME______________________________________Date_________SSN__________________________

Address_____________________________City__________________State_______Zip-____________

Birth date_________________Home phone#______________________Work phone #________________

Cell Phone ____________________ Email Address ____

Are you___minor___married___divorced___widowed___single___separated___

Your employer________________________________Occupation__________________________________ Spouse

or Parent Name_________________________DOB_________SSN__________________________

Person to contact in case of emergency : Name_____________________Tele#______________________

Number of children__________________

INSURANCE INFORMATION

Name of insured_______________________________Relationship to patient________________________

Birth date of insured______________________SSN____

Name of employer__________________________________Work phone #__________________________

Insurance company______________________________Phone#________________Group#_____________

Deductible?_____________How much have you met of deductible?_____________

I take full responsibility for payment of this account.

Signature:___________________________________

We do not bill secondary insurance companies. We will furnish you with the necessary form so that you may bill your additional insurance company to ensure your reimbursement as quickly as possible.

PATIENT CONDITION

Reason for visit____

When did your symptoms appear?____

Is this condition getting progressively worse? ____yes _____no _____unknown

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

Type of pain ___sharp___dull___throbbing___numbness___aching___shooting___burning___
___tingling___cramps___stiffness___swelling___other

How often do you have this pain?______________________________

Is it constant or does it come and go?___________________________

Does it interfere with your ____work ____sleep____daily routine ____recreation

Activities or movements that are painful to perform ____sitting ____standing ____walking ____bending
____lying down

What is your general physical condition at present?____

Are you under a physician's care at the present time?____

For what reason?____

HEALTH HISTORY

What treatments have you received for your condition? Medications__ Surgery__ Physical Therapy __
Chiropractic care__ None__ other__
Name of Doctor who have treated you for your condition?______________________________________

Date of last: Phy.Ex.______, Spinal XR's________,Chest XR's________,MRI/CAT________Other_____

Have you or immediate family member ever been diagnosed with or told you have had a:
Ministroke? Yes___No___ Transient Ischemic attack (TIA) Yes_____No__AneurysmY__N__
Have you ever experienced temporary loss of vision in one eye? Yes____No_____
Have you ever collapsed without losing consciousness or fainting? Yes___No____

Check those conditions which are applicable: cataracts__hepatitis__osteoporosis__alcoholism__hernia__
Pacemaker__thyroid problem__allergy shots__arthritis__breastlump__cancer__depression__emphysema__
Glaucoma__heart disease__pinched nerve__miscarriage__polio__stroke__ulcers__other__

Exercise	Work Activity	Habits
__none	sitting__	smoking__/pack a day__
__moderate	standing__	alcohol__/drinks a week__
__daily	light labor__	coffee/caffeine drinks/cups a day__
__heavy	heavy labor	high stress level/reason_____________

Injuries/surgeries you have had: Falls____________________Head injuries__________________Broken
Bones_____________Dislocations_________________Surgeries________________________________

Medications____Allergies_
____
Vitamins/Herbs/Minerals____

AUTHORIZATION
I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the chiropractor to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such chiropractic care to third party payers and/or health practitioners. I authorize and request my insurance company to pay directly to the chiropractor, insurance benefits otherwise payable to me. I understand that my chiropractic insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents. In the event that my insurance denies payment for a service(s), I agree to be fully responsible for the amount.

Signature:_________________________________Date________________________