

*****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__ Aneurysm Y__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.

Signature: _____ Date _____