EMERALD COAST CHIROPRACTIC

Please print clearly and fill in completely

Name _____ Home Phone _____
Address _____ Cell Phone _____
City _____ State _____ Zip _____
Date of Birth _____ SSN#_____
E-mail_____
Marital Status (circle one) Single Married Other # of Children _____

Whom may we thank for referring you to our clinic? _____

Your Occupation _____
Your Employer _____ Work Phone _____
Spouse's Name _____
Spouse's Employer _____ Work Phone _____

Insurance Information

Insurance Company _____ Phone Number _____
Member/Subscriber Name _____ ID/Member Number _____

Health History

Give reason for seeking chiropractic care _____
Date of Accident/Onset _____
Is this condition due to a/an (circle one) Auto Accident Work Injury Other
Are you under the care of any other doctor? Yes No If yes, the condition being treated for?

_____
List any current medications: _____
List any past surgeries and dates: _____
List any past accidents and dates: _____
List any x-rays you've had in past 2 years: _____

Chiropractic History

Have you ever been to a chiropractor before? Yes No
If Yes, Doctor's Name _____ Location _____
Date of last visit _____ Reason for care _____
Are other family members under chiropractic care? Yes No Who? _____

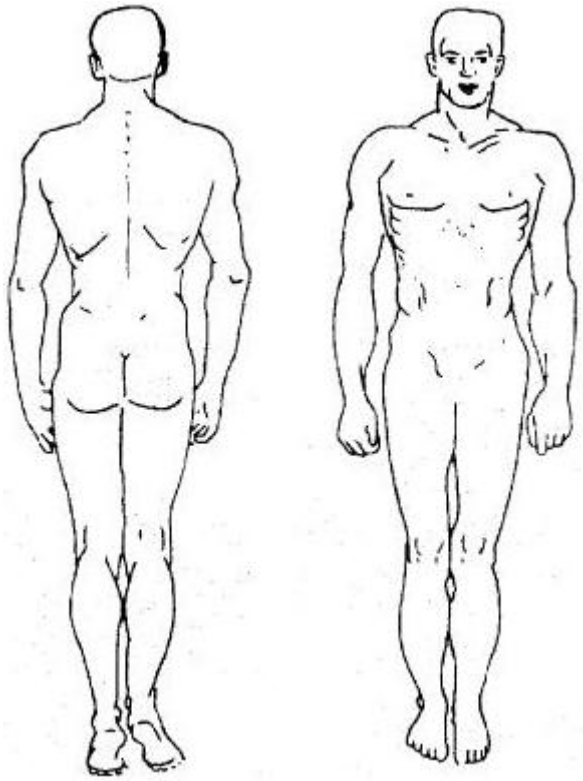
FEMALES: Is there any possibility of you being pregnant? Yes No

Please Fill In Below

If you have had, or if you suffer from the following, *Please Check* ✓

Condition, Symptom Or Problem	Do you have ?
Headache	❑
Migraines	❑
Neck Pain	❑
Shoulder Pain	❑
Arm/Hand Pain	❑
Mid Back Pain	❑
Low Back Pain	❑
Hip Pain	❑
Leg/Foot Pain	❑
Disc Problems	❑
Arthritis	❑
Other joint pain	❑
Numbness	❑
Joint Swelling	❑
Dizziness	❑
Nausea	❑
Weakness	❑
Fatigue	❑
Nervousness	❑
Insomnia	❑
Heart Problems	❑
Vision Changes	❑
Nose Bleeds	❑
Ringing in Ears	❑
Earaches	❑
Hearing Loss	❑
Cough	❑
Chest pains	❑
Female problems	❑
Allergies	❑
Asthma	❑
Cancer	❑
Osteoporosis	❑
Diabetes	❑
Hypoglycemia	❑
Digestive problem	❑
Urinary Problems	❑
Frequent colds	❑
Skin conditions	❑

Please circle areas of pain or discomfort



Rate your pain level on a scale from 1 to 10

0 1 2 3 4 5 6 7 8 9 10

Below, Please Fill In Any Other Health Information You Feel We Might Need For Your Care.

_____

_____

_____

_____

_____

_____

Thank you for being complete and thorough.

Your Signature Below Please:

_____

Date: _____

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PATIENT CONSENT AUTHORIZATION

CONSENT FOR TREATMENT: I voluntarily consent to the rendering of care, including treatment and performance of diagnostic procedures. I understand that I am under the care and supervision of the attending physician and it is the responsibility of the staff to carry out the instructions of such physician(s).

ASSIGNMENT OF BENEFITS: I hereby assign payment directly to the physician(s) accepting this assignment of medical benefits applicable and otherwise payable to me but not to exceed the physician's regular charges. I understand that I am financially responsible for charges not covered by this assignment or for any and all charges that the insurance carrier declines to pay.

RELEASE OF INFORMATION: The physician(s) may disclose all or part of the patient's record to any person or corporation which is or may be liable under a contract to the physician(s) or to the patient or to a family member or employer of the patient for all or part of the physician(s) charges, including but not limited to, insurance companies, worker's compensation carriers, welfare funds, or the patient's employer.

MEDICARE & MEDICAID PATIENT CERTIFICATION - PATIENT'S CERTIFICATION & AUTHORIZATION TO RELEASE INFORMATION & PAYMENT REQUEST: I certify that the information given by me in applying for payment under Title XVIII and/or Title XI of the Social Security Act, is correct. I authorize any holder of medical or other information about me, to release to the Social Security Administration or its intermediary carriers, any information needed for this or related Medicare or Medicaid claim. I request that payment of authorized benefits be made on my behalf. I assign the benefits payable for physician(s) services. I understand that I am responsible for my health insurance deductibles and coinsurance.

_____

Print Patient's Name

_____

Patient's Signature

FEMALE PATIENTS ONLY: Verification of non-pregnancy [if applicable]

Date: _____

Initial only: _____

By my initial above, I do hereby state that to the best of my knowledge, I am not pregnant nor is pregnancy suspected at this time.

501 Harbor Boulevard, Suite C • Destin, Florida 32541 • 850.654.1850 • 850.654.9994 (f)

destinchiropractor.com

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ACKNOWLEDGMENT OF RECEIPT
OF
NOTICE OF PRIVACY PRACTICES

I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have either read or waived the opportunity to read them, and understand the Notice of Privacy Practices. I understand that this form will be placed in my patient chart and maintained for six years.

_____ _____

Patient name (please print) Date

_____

Parent, guardian or patient's legal representative

_____

Signature

THIS FORM WILL BE PLACED IN THE PATIENT'S CHART AND MAINTAINED FOR SIX YEARS.

CLICK HERE TO SUBMIT FORMS

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