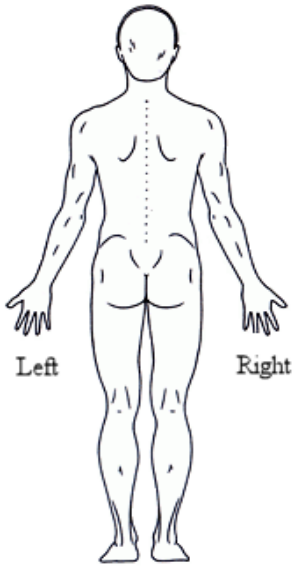
Downtown Chiropractic Patient Case History

(Please print neatly)

Name _____ Sex M F Today's Date_____
Address _____ State_____ Zip_____
Date of Birth _____Age_____ Social Security #_____
Phone # _____W.Phone_____ Occupation _____
Email Address:_____
Have you ever received Chiropractic Care? Yes__ No__ If yes when/who?_____
Who can we thank for referring you to this office?_____

Please circle the area(s) of complaint:



Please circle the sensation(s) you feel:

Stabbing
Burning
Dull Pain
Throbbing
Deep Ache
Numbness/Tingling
Radiating to:_____
Other:_____

Intensity Level (0=no pain, 10=worst pain)
1 2 3 4 5 6 7 8 9 10

Does anything **aggravate** this complaint?
_____

Does anything relieve the complaint?
_____

Have you seen anyone else for this complaint?
Who?_____When?_____

Please read this notice: *This information is provided for your understanding and to clarify the* ***financial policies*** *of Downtown Chiropractic, Inc. This way we can devote our efforts to helping you get the best results in the shortest amount of time.*

We accept cash, personal checks, Visa, MasterCard, and Discover. Patients are responsible for **full payment** at the time of service. Any other payment arrangements must be pre-authorized. If your care is covered by group insurance or a third party, we will supply you with documentation to help you receive benefits. Please remember that all professional services are rendered and charged to the patient receiving care, **not** the third party. In addition, we **will not** become involved in disputes with your insurance company regarding deductibles, co-payments, covered charges, secondary insurance, "usual and customary" and "not medically necessary" charges, etc., other than to supply factual information. Should x-rays be indicated, our office will refer you to an appropriate facility for those procedures.

Any outstanding balances are billed monthly on the first of each month and are due 10 days after the invoice date. Returned checks are subject to a $30.00 fee. Balances unpaid for more than 60 days will accrue interest charges of $10 per month, plus any legal or collection fees.

I have read the above information and certify it to be true and correct to the best of my knowledge, and hereby authorize this office to provide me/child with chiropractic care, in accordance with this state's statutes. I have also read and/or received a copy of the privacy policy of Downtown Chiropractic, Inc. regarding disclosure of my medical information.

Patient or Guardian Signature _____ Date _____