Enloe Chiropractic "Life" Center

Welcome to our office! Please take your time and fill this paperwork out to the best of your ability so that we can begin to return you to optimum health!

– Dr. John

Date of Birth: _____ Age: _____ Sex: M/F

Last:_____ First: _____ Middle Initial: _____

Address:_____ City: _____ ST:_____ Zip:_____

Phone: (H)_____ (C)_____ (W)_____

Email:_____ Emergency Contact and #:_____

Your Occupation:_____ Employer:_____

Spouse's Name:_____

Have you been to another doctor for this problem? Yes / No Who/Where? _____

Who may we thank for referring you to this office?_____

WHAT BRINGS YOU TO OUR OFFICE? Please provide as much detail as possible.

PRIMARY COMPLAINT: _____

SECONDARY COMPLAINT:_____

Date when symptom first appeared _____ Did it begin: Gradual Sudden Progressive over time

What makes the symptoms increase? _____ What relieves the symptoms? _____

Type of Pain: Sharp / Dull / Ache / Burn / Throb Does the Pain Radiate into your: Arm / Leg / Does not radiate

Do you have Numbness or Tingling? Yes / No How often do you experience these symptoms? _____

Please rate the intensity of your symptoms on a scale of 1 – 10 (1 being no symptoms, 10 being extreme) _____

Please list all previous treatments for this condition (give doctor's name and dates if possible)_____

_____

IS THIS CONDITION A RESULT OF AN ACCIDENT OF ANY KIND? Y/N _____

Please list all surgeries, injuries, accidents, falls, etc / diseases you have or have had in the past: (ex: heart attack, diabetes, cancer, etc.)

_____

_____

_____

_____

_____

Please mark off the areas of your complaint on the diagrams with the following indicators:

PPP = pain

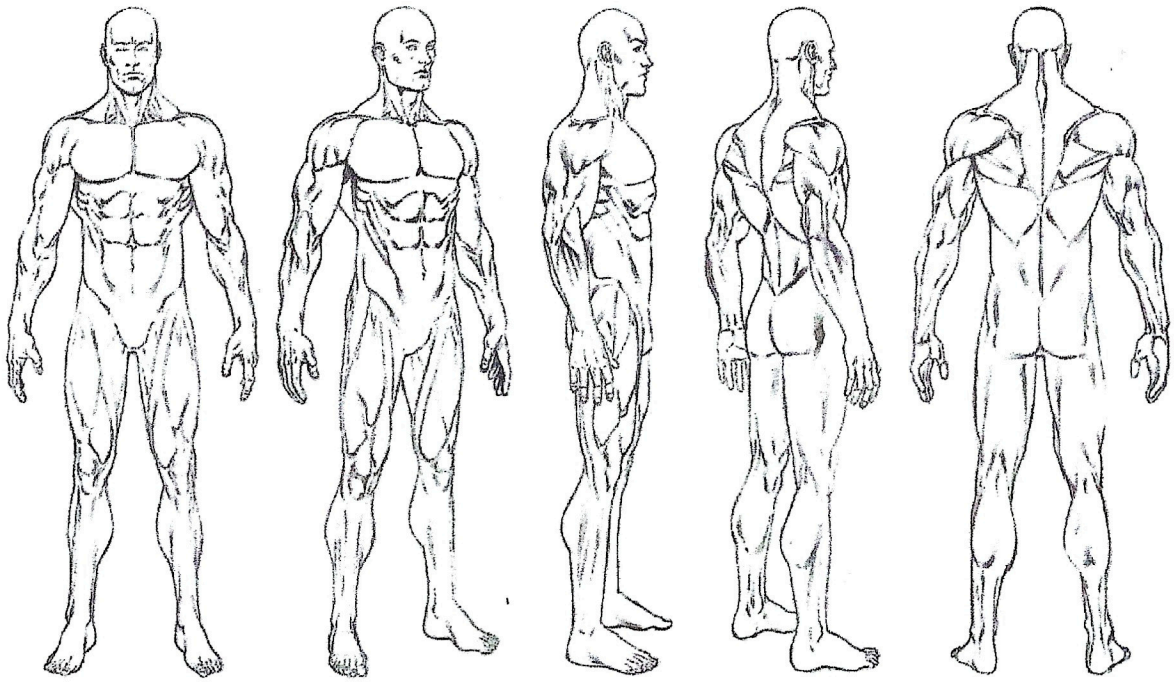
NNN = numbness

TTT = tingling

BBB = burning

CCC = cramping

XXX = other



I have read the **INFORMED CONSENT TO CHIROPRACTIC TREATMENT**. I have had the opportunity to have any questions answered to my satisfaction. I have fully evaluated the risks and benefits of undergoing treatment. I have freely decided to undergo the recommended treatment, and hereby give my full consent to treatment.

PATIENT SIGNATURE
X_____DATE_____

I have fully read the **TERMS OF ACCEPTANCE FOR CHIROPRACTIC HEALTH CARE** and fully understand and therefore accept Chiropractic care on this basis.

PATIENT SIGNATURE
X_____DATE_____

I have read the **CONSENT FOR USE OR DISCLOSURE OF HEALTH INFORMATION** and fully understand my rights and agree to its terms.

PATIENT SIGNATURE
X_____DATE_____

CONSENT TO EVALUATE AND ADJUST A MINOR CHILD:

I, _____ being the parent or legal guardian of _____have read and fully understand the above informed consent and hereby grant permission for my child to receive chiropractic care.

PREGNANCY RELEASE:

This is to certify that to the best of my knowledge I am not pregnant and the doctor has my permission to perform and x-ray evaluation. I have been advised that an x-ray can be hazardous to an unborn child.

_____
(SIGNATURE)

PATIENT SIGNATURE_____**DATE**_____

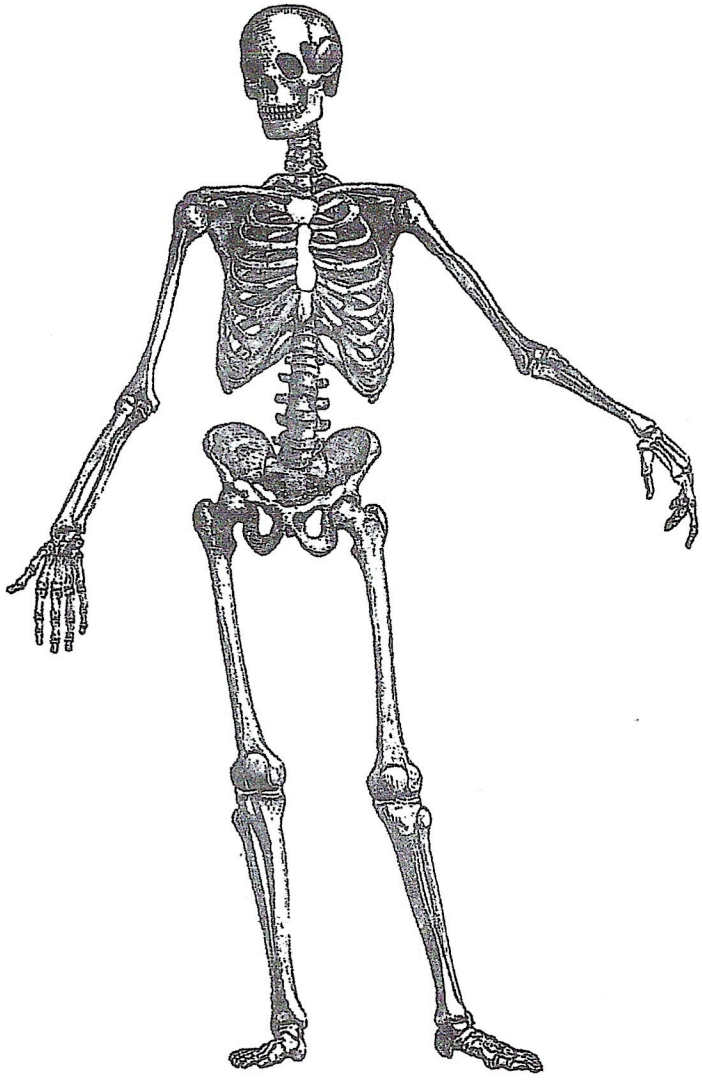
Medical History

Please check all that apply

___ Emphysema
___ Tuberculosis
___ Pneumonia
___ Bronchitis
___ Asthma
___ Allergies
___ Heart Disease
___ Stroke
___ High Blood Pressure
___ Elevated Cholesterol
___ Diabetes
___ Venous Thrombosis
___ Hepatitis A
___ Hepatitis B
___ Hepatitis C
___ Cirrhosis
___ Anemia
___ Thyroid Trouble
___ Gallbladder Disease
___ Ulcers
___ Frequent Urinary Tract Infections
___ Sexually Transmitted Infections
___ Prostate Trouble
___ Cancer
___ Arthritis
___ Osteoporosis
___ Fractures
___ Migraines
___ Depression
___ Anxiety or Panic Disorder
___ Posttraumatic Stress Disorder
___ Alcohol or Substance Use Problem

Other: _____

This section is very important to Dr.Enloe , because certain conditions have a direct effect on the healing time of the body!



ENLOE CHIROPRACTIC "LIFE" CENTER

ABOUT OUR FEES

We realize that there is no amount of money that will accurately reflect the cost of an adjustment when it restores lost health. Therefore, we ask you to read the following and let us know which way you expect to handle your account. We will do our best to help you. All we ask is that you do your best. Please mark the fee schedule which best suits your situation:

1. ____ **General Insurance**: Your insurance company will pay for a certain percentage of your benefits. You are responsible for the deductible and any portion your insurance does not pay.

2. ____ **Medicare: You are responsible for your yearly deductible and copay.**

3. ____ **Non-Insured: At the present time you are not covered by insurance.**

4. ____ **Personal Injury**: You have been in a car accident and will either be: A) filing through your car insurance, B) contacting a lawyer, or C) receiving a settlement.

We ask that you kindly read and sign our financial policy as well as complete our patient information form prior to see the doctor.

Payment for services is due at the time services are rendered. We accept cash, checks, credit and debit cards for your convenience. We will be happy to help you process your insurance claims. **We accept assignment from most insurance companies; however, you must understand that:**

Your insurance policy is a contract between you, your employer and the insurance company. We are NOT a party to that contract. Our relationship is with you, not your insurance company.

All charges are your responsibility, whether your insurance company pays us or not. Not all services are covered benefits in all contracts. Some insurance companies arbitrarily select certain services they will not cover. Fees for these services, along with unpaid deductibles and co-payments are due at the time of treatment.

If the insurance company does not pay your balance in full within 45 days, we kindly ask that you contact your insurance carrier to help speed things up.

If the insurance company does not pay within 45 days, we require you to pay the balance due.

Returned check and balances older than 60 days may be subject to an additional collection fee and interest charges of 1 ½ % per month.

If you are in our office due to a personal injury covered by you auto policy, we will make every attempt to process your claims quickly, some of the above statements may not apply due to certain state laws. In Personal injury cases we require a letter of protection from your attorney for payment.

We understand that temporary financial problems may affect timely payment of your balance. We encourage you to communicate any such problems so that we can assist you in the management of your account.

Remember, our primary goal is to help you become healthy. If health is your priority, we will work with you in any way to help you reach that goal. We will do our best for you, if you do your best.

Thank You,

_____ _____

PRINT NAME SIGNATURE

_____

DATE