CONFIDENTIAL PATIENT INFORMATION

(Please Print Clearly)

Name ______________________ Email ______________________

Address ______________________ City ______________ Zip __________

Home Phone ______________ Work Phone ______________ Cell Phone ______________

Age ______ Birth Date ______________ Marital Status: M S W D Number of Children ______________

Occupation ______________ Employer ______________________

Address ______________________ City ______________ Zip __________

Name of Spouse ______________________ Occupation ______________

Employer ______________________ Office Phone ______________

Nearest Relative ______________________ Relatives Phone ______________

Referred By ____

Primary Physician ______________________ Address ______________________

Date of Last Physical Exam Medical ______________ Chiropractic ______________

List Operations You've Had ______________________ When ______________

Have You Ever Suffered From:

1. Dizziness ______________
2. Backache ______________
3. Heart Trouble ______________
4. Diabetes ______________
5. Tuberculosis ______________
6. Arthritis ______________
7. Headaches ______________
8. Numbness ______________
9. Asthma ______________
10. Neuritis ______________
11. Digestive Disorders ______________
12. Nervousness ______________
13. Sinus Trouble ______________
14. Anemia ______________
15. Rheumatic Fever ______________
16. Cancer ______________

Purpose of this Appointment ____

Other Doctors Seen for this Condition ____

Is Your Condition from a Work Injury? Yes______ No______ Auto Accident Yes______ No______

Have You Been Treated for Any Health Condition by a Physician in the Last Year? Yes______ No______

Describe ____

What Medicines or Drugs Are You Taking? ____

Remarks and Additional Information ____

____

Payment is Expected at Time of Visit! Name of Person Responsible for Payment ______________________

Are You Insured? Yes______ No______ Company ______________________

Policy Holder ____

I UNDERSTAND AND AGREE THAT HEALTH AND ACCIDENT POLICIES ARE AN ARRANGEMENT BETWEEN AN INSURANCE CARRIER AND MYSELF, FURTHERMORE, I UNDERSTAND THAT FRANKFORT CHIROPRACTIC/SPINAL REHABILITATION & PHYSICAL THERAPY WILL PREPARE ANY NECESSARY REPORTS AND FORMS TO ASSIST ME IN MAKING COLLECTION FROM THE INSURANCE COMPANY AND THAT ANY AMOUNT AUTHORIZED TO BE PAID DIRECTLY TO FRANKFORT CHIROPRACTIC/REHABILITATION & PHYSICAL THERAPY WILL BE CREDITED TO MY ACCOUNT ON RECEIPT. HOWEVER, I CLEARLY UNDERSTAND AND AGREE THAT ALL SERVICES RENDERED TO ME ARE CHARGED DIRECTLY TO ME AND THAT I AM PERSONALLY RESPONSIBLE FOR PAYMENT. I ALSO UNDERSTAND AND AGREE THAT IF I SUSPEND OR TERMINATE MY CARE AND TREATMENT, ANY FEES FOR PROFESSIONAL SERVICES RENDERED ME WILL BE IMMEDIATELY DUE AND PAYABLE. A CHARGE WILL BE MADE FOR PREPARATION OF ADDITIONAL INSURANCE FORMS. ALL ACCOUNTS PAST DUE 90 DAYS WILL INCUR A 1.5% MONTHLY/18% ANNUAL INTEREST FEE. ALL ACCOUNTS PAST DUE 90 DAYS WILL BE PLACED IN COLLECTION. I UNDERSTAND AND AGREE TO REIMBURSE THE FEES OF ANY COLLECTION AGENCY, WHICH MAY BE BASED ON A PERCENTAGE AT A MAXIMUM OF 33% OF THE DEBT, AND ALL COSTS, AND EXPENSES, INCLUDING A REASONABLE ATTORNEY'S FEE INCURRED BY FSRPT IN COLLECTION OF ANY BALANCE ON MY ACCOUNT.

Patient's Signature ______________________ SS# ______________ Date ______________

Guardian or Spouse's Sig. Authorizing Care ______________________ Date ______________

Info Taken By ______________________ Date ______________