Patient Information

Chart # ______________

First Name: _________________________ Nick Name: ___________MI: ____ Last Name: _____________________________

Mailing Address: ____Apt: ______________

City: ____ State: ___________ Zip: ____________________________

Marital Status: S M W D Spouse: ____

DOB: ____________________Home Phone: _______________________________ Work Phone:__________________________

Cell Phone: ____________________________________ Email Address: ____

Occupation: _____________________________________ Employer: ____

Employer Address: ____

Emergency Contact: Who: __________________________________ Phone: ____

Whom may we thank for referring you to our office? ____

Would you like to receive our newsletter via Email?____

Insurance Information

We will make a copy of your insurance card/s. However, please complete the following information.

Are you the policy holder? Y N If no, who is policy holder: Spouse Parent Employer Other

Policy Holder's Name:

First Name: ____ M.I. __________ Last Name: ______________________________

Policy Holder's Date of Birth: ______________________Policy Holder's Employer: __________________________________

Do you have secondary insurance coverage? Y N If yes, please complete the following:

Policy Holder's Name:

First Name: ______________________________________ M.I. ___________ Last Name: _______________________________

Policy Holder's Date of Birth: ____________________ Policy Holder's Employer: ___________________________________

DIRECT PAYMENT: **I authorize payment of medical benefits directly to LAKELAND CHIROPRACTIC CLINIC (Bruce F. Hurst, D. C.) for services rendered to me.**

AUTHORIZATION AND ASSIGNMENT: LAKELAND CHIROPRACTIC CLINIC is authorized to release any information deemed appropriate concerning my physical condition to any insurance company, attorney, or adjustor in order to process my claim for reimbursement of charges incurred. In the event any insurance company obligated by contractual agreement refuse payment for services rendered to me, I authorize any appropriate action to be taken on my behalf to resolve said claim as necessary.

I understand that this chiropractic office will prepare necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to this chiropractic office will be credited to my account upon receipt. Deductibles and/or co-pay are due and payable at the time of service, or on a regular basis (daily, weekly, monthly) as agreed with the financial secretary. I also understand that services may be necessary that are not covered by my insurance plan. This may be because the benefit has been exhausted, the primary care physician and/ or insurance carrier will not authorize chiropractic care, or the services or supplies are not within the scope of the plan. (Maintenance care, re-examinations, exercise instruction & supervision, soft tissue therapy, supports, pillows heel lifts, or supplements, etc.)

I, the undersigned, authorize release of information; direct payment; and acknowledge that I have been advised that portions of my care may not be covered under terms of my health plan. I agree to be personally responsible for any service not covered by my health plan.

THIS AUTHORIZATION IS TO REMAIN IN EFFECT UNTIL REVOKED IN WRITING

Patient's/ Parent's/ Guardian's Signature: ___________________________Date_____________

HISTORY

Name:____Date:__________ Chart#__________

PAST INJURY

What work related claims have you had?

Year_____ Injury____ Recovered?_______

Year_____ Injury____ Recovered?_______

Others____

What non work related injuries of significance have you had?

Year_____ Injury____ Recovered?_______

Year_____ Injury____ Recovered?_______

Others____

PAST MEDICAL HISTORY

List types and year of serious illnesses, fractures, or surgeries ____

____

List significant medical conditions which run in your family ____

____

CURRENT MEDICAL HISTORY

List names and specialties of doctors that you see ____

____

Medications you are now taking

Name:	Reason:	Name:	Reason:
____________________	____________________	____________________	____________________
____________________	____________________	____________________	____________________
____________________	____________________	____________________	____________________

Review of System Problems:

Head, Eyes, Ears, Nose, Throat

☐ History of Concussion/Brain Injury ☐ Dizziness

☐ Wear Glasses/Corrective Lenses ☐Changes in Vision ☐ TMJ

☐ Wear Hearing Aid ☐Changes in Hearing ☐Ringing in Ears/Tinnitus

☐ Environmental Allergies ☐Seasonal Allergies

Other: ____

Cardiopulmonary

☐ Raynaud's ☐ Palpitations ☐ Ankle Swelling ☐Anemia

☐ Difficulty Breathing ☐ Asthma ☐ COPD ☐ Other ______________________________

Gastrointestinal

☐Heartburn/Acid Reflux ☐Irritable Bowel Syndrome ☐ Other ______________________________

Genitourinary

☐ Hernia ☐ Incontinence ☐ Other ______________________________

Psychological

☐ Depression ☐ Anxiety ☐ Phobias ☐Non-refreshing Sleep

☐ Mood Swings ☐ Other ______________________________

Are you now, or do you think may be pregnant? ◻ Yes ◻ No

Age: ____ Gender: M/F Height: ______ Weight:_____ Right/Left Handed

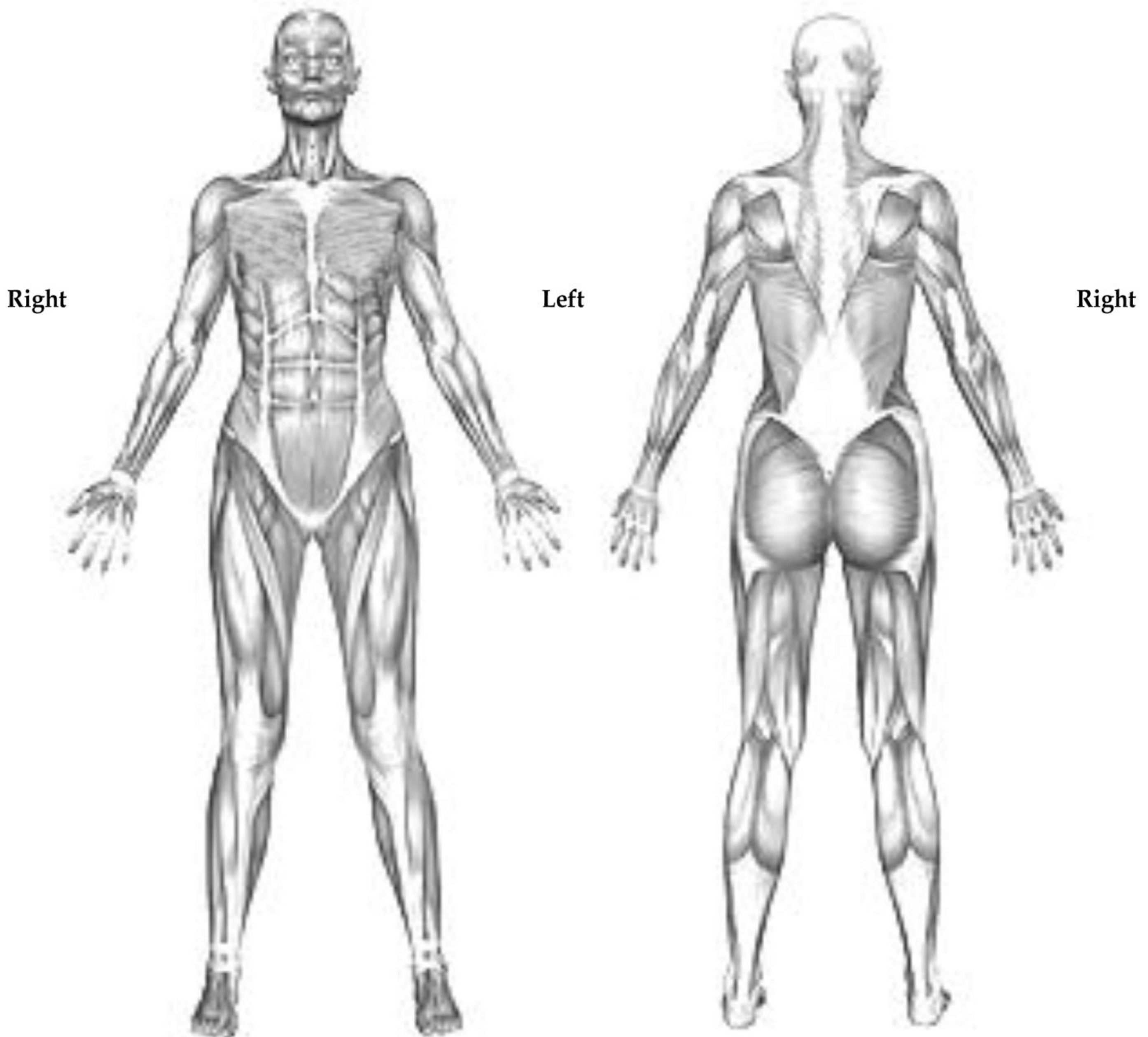
Name: ____ **Date:** _____________ **Chart #:**________

Check the areas in which you now have symptoms:

Eyes Δ	Breathing Δ	Intestines/Colon Δ	Muscles Δ
Ears Δ	Heart Δ	Kidney/Bladder Δ	Sleep Δ
Nose-throat Δ	Stomach Δ	Hormones Δ	Mood Δ

Numbness	Tingling	Burning	Stabbing	Aching	Stiffness
____	ooo	xxx	///	^^^	+++

FRONT **BACK**



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