

Thank you for selecting CREEKWOOD CHIROPRACTIC PC.

We will strive to provide you with the best possible care. To help us meet your entire healthcare needs, please fill out this form completely. If you have any questions or need assistance, please ask & we will be happy to help.

Date _____

Patient/Guarantor Information

Check Appropriate Box Minor Single Married Divorced Widowed Separated

Name _____ DOB ____/____/____

Soc Sec #: ____/____/____

Home Phone _____ Cell Phone _____

Address _____ City _____ St _____ Zip _____

Patient's or Parent's Employer _____ Work Ph _____

Employer Address _____ City _____ St _____ Zip _____

Spouse, Parent or Other _____ DOB ____/____/____

Soc Sec #: ____/____/____

Home Phone _____ Cell Phone _____

Address _____ City _____ St _____ Zip _____

Employer _____ Work Ph _____

Employer Address _____ City _____ St _____ Zip _____

If Patient is a Student, Name of School/College _____

City _____ State _____

Person to Contact in Case of Emergency _____

Phone _____ Address _____

Non Family Member Contact _____

Phone _____ Address _____

Who is responsible for the patient's medical care? _____

Whom May We Thank for Referring You? _____

Insurance Information

Name of Insured _____ Relationship to Patient _____
DOB _____ Soc Sec # _____ / _____ / _____ Date Employed _____
Name of Employer _____ Work Phone _____
Employer Address _____ City _____ St _____ Zip _____
Insurance Company _____ Group # _____ Union or Local _____
Ins. Co Address _____ City _____ St _____ Zip _____
Insurance Company Phone # _____

DO YOU HAVE ANY ADDITIONAL INSURANCE? Yes No If YES, Complete the following:

Name of Insured _____ Relationship to Patient _____
DOB _____ Soc Sec # _____ / _____ / _____ Date Employed _____
Name of Employer _____ Work Phone _____
Employer Address _____ City _____ St _____ Zip _____
Insurance Company _____ Group # _____ Union or Local _____
Ins. Co Address _____ City _____ St _____ Zip _____
Insurance Company Phone # _____

Authorization and Release

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the physician to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such care to third party payors and/or health practitioners. I authorize and request my insurance company to pay directly to the physicians office, insurance benefits otherwise payable to me. I understand that my insurance carrier may pay less than the actual bill for services. I understand I am responsible for all copays, deductibles, co-insurance and balances.

X _____
Signature of Patient (or Parent if minor)

This form needs to be filled out completely in order for our services to be provided.

Patient Name _____

Date _____

Reason for today's visit: Emergency New Injury Old Injury Chronic Pain Wellness Visit

Are you in pain: Yes No Rate your pain with the following scale

Discomfort 1 2 3 4 5 6 7 8 9 10 Intense

Did your injury occur during: Work Sports/ play Auto Accident Routine/ Household activity

When did your condition/ accident occur? ____/____/____ Where did your injury occur?_____

Please explain what happened: _____

Is your condition getting worse? Yes No Constant Comes and goes

Is your condition interfering with your: Work Sleep or Daily routine? If so, how: _____

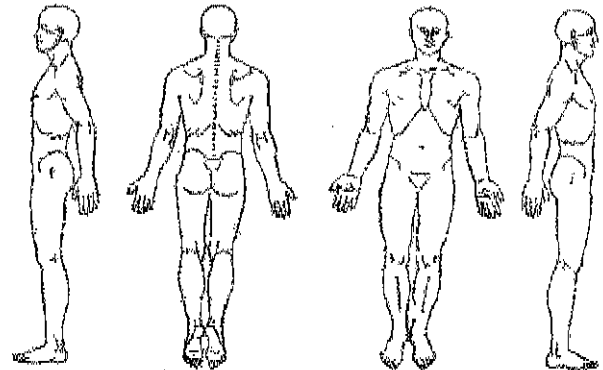
Has this or something similar happened in the past?
 Yes No Explain: _____

Using the adjacent body charts, please circle all affected Areas.

Have you been treated by a medical physician for this Pain? Yes No If so, where? _____

Have you ever been treated by a chiropractor? Yes No
Clinic or Dr's Name: _____

Clinic Phone#: _____



Left Back Front Right

Are you taking any of the following medications? Nerve Pills Pain killers (including aspirin) Muscle relaxes Blood thinners

Tranquillizers Insulin Other(s) _____

Do you have or have you had any of the following diseases, medical conditions or procedures?

- | | | | | |
|------------------------------|----------------------------------|-------------------------|--|---------------------------|
| Y N Heart Attack/ Stroke | Y N Heart/ Surg./ Pacemaker | Y N Heart Murmur | Y N Congenital Heart Defect | Y N Mitral Valve Prolapse |
| Y N Artificial Valves | Y N Alcohol/ Drug Abuse | Y N Venereal Disease | Y N Hepatitis | Y N Anemia/ Diabetes |
| Y N Shingles | Y N Cancer | Y N Frequent Neck Pain | Y N Glaucoma | Y N Kidney Problems |
| Y N High/ Low Blood Pressure | Y N Psychiatric problems | Y N Rheumatic Fever | Y N Severe/ Frequent Headaches | Y N Tuberculosis |
| Y N Ulcers/ Cellitis | Y N Fainting/ Seizures/ Epilepsy | Y N Sinus Problems | Y N Emphysema/ Asthma | Y N Arthritis |
| Y N Difficulty Breathing | Y N Chemotherapy | Y N Lower Back Problems | Y N Artificial Bones/ Joints/ Implants | |

Please list any surgeries with dates and/ or any other serious medical condition(s) not listed above:

List any past serious accidents with dates:

Please list anything that you may be allergic to:

Patient Name _____

Date _____

Family Health History:

Do you take Supplements or Vitamins? Yes No Do you exercise? No Yes _____ hours per week

Do you smoke? No Yes How much? _____ How Long? _____

Are you wearing: Shoe lifts Inner soles Arch supports Are you dieting: No Yes Since ____/____/____

For Women: Are you taking Birth Control? Yes No

Are you nursing? Yes No Are you pregnant? Yes No If so, how many weeks? _____

- o We invite you to discuss with us any questions regarding our services. The best services are based on a friendly, mutual understanding between provider and patient.
- o Our policy requires payment in full for all services rendered at the time of visit, unless other arrangements have been made with the business manager. If account is not paid within 90 days of the date of service and no financial arrangements have been made, you will be responsible for legal fees, collection agency fees, interest charges and any other expenses incurred in collecting your account.
- o I authorize the staff to perform any necessary services needed during diagnosis and treatment. I also authorize the provider to release any information required to process insurance claims.
- o I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes to the information I have provided.

Signature _____

Date ____/____/____

Adult patient Parent or Guardian Spouse

