APPLICATION FOR CARE - LOWERY FAMILY CHIROPRACTIC

The following information is needed in order to better serve you. Please complete all questions. If you need help please ask the receptionist. PLEASE PRINT

PERSONAL INFORMATION

Today's Date _____/_____/_____ **Social Security #** _____ (Insurance Purposes)

Last Name_____ **First Name**_____ **Middle Initial** _____

Home Phone (____)_____-_____ **Work Phone** (____)_____-_____ **Cell phone** (____)_____-_____ (Star the best number to reach you)

Address _____**City**_____ **State**_____ **Zip**_____

Birthdate_____ **Marital Status:** S M W D **Referred to our office by:** _____

Please Circle Payment Type: HEALTH INSURANCE CASH CHECK CREDIT/DEBIT CARD FLEX ACCT. WORK COMP. AUTO INS.

Employer_____ **Address**_____ **City**_____ **State**_____ **Zip**_____

INSURANCE INFORMATION

Primary Insurance Co. _____ Group # _____ I.D. # _____

Policy Holders Name_____ Policy Holders Birthdate_____ Policy Holders SS # _____-_____-_____

Secondary Insurance Co. _____ Group # _____ I.D. # _____

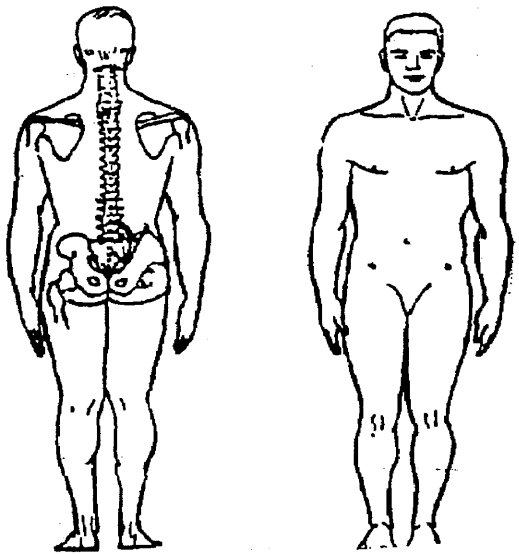
SPOUSE'S INFORMATION

Name of Spouse or Parent: _____**Birthdate** _____ SS# _____-_____-_____

Employer _____Address _____ City_____ State_____ Zip

COMPLETE THESE DIAGRAMS

If you are in pain, please mark the exact location of your pain on the diagram. Also describe the type and frequency of your pain, as well as any activity which brings on or aggravates the pain. For example, dull, sharp, consistent, off & on, when standing, when sitting, etc.



MAJOR COMPLAINTS

(Please list any condition you are being treated for, or are currently experiencing.)

_____

_____

_____

_____

ACCIDENT INFORMATION

Is your condition due to an accident? YES NO *If yes, **Date of Accident** _____

Type of accident: (Circle One) Auto Work/On the job At home Other _____

Records Release: I authorize you to release any information including diagnosis and records of treatment to _____ Ini-

I (we) agree to pay for services rendered to the above mentioned patient as the charge is incurred. I understand and agree that health & accident insurance policies are an arrangement between my insurance carrier and myself and that I am personally responsible for payment of any and all services covered or not covered. I also understand that if I suspend or terminate my care and treatment, any fee for professional services rendered me will be immediately due and payable.

Patient Signature_____ **Date**_____

or Guardian Signature_____ Date_____

NOTICE: Full payment for services rendered is due and expected at each visit. If for any reason this request cannot be met, arrangements should be made **in advance** before seeing the doctor.

Confidential Patient Case History

Dear Patient: Please complete this questionnaire. Your answers will help us determine if chiropractic can help you. If we do not sincerely believe you condition will respond satisfactorily, we will not accept you case. THANK YOU.

Name _____ Date _____

Please check the appropriate box for any of the following symptoms which you now have or have had previously. We want all the facts about your health before we accept your case. THIS IS A CONFIDENTIAL HEALTH REPORT.

O – OCCASIONAL
F – FREQUENT
C – CONSTANT

O	F	C	
			GENERAL
☐	☐	☐	Allergy
☐	☐	☐	Chills
☐	☐	☐	Convulsions
☐	☐	☐	Dizziness
☐	☐	☐	Fainting
☐	☐	☐	Fatigue
☐	☐	☐	Headache
☐	☐	☐	Loss of sleep
☐	☐	☐	Loss of weight
☐	☐	☐	Nervousness/depression
☐	☐	☐	Numbness
☐	☐	☐	Sweats
☐	☐	☐	Tremors
			MUSCLE & JOINT
☐	☐	☐	Arthritis
☐	☐	☐	Bursitis
☐	☐	☐	Foot trouble
☐	☐	☐	Low back pain
☐	☐	☐	Neck pain or stiffness
☐	☐	☐	Pain between shoulders
			Pain or numbness in:
☐	☐	☐	Shoulders/Elbows
☐	☐	☐	Hands/Arms
☐	☐	☐	Hips
☐	☐	☐	Legs/Knees
☐	☐	☐	Feet
☐	☐	☐	Painful tail bone
☐	☐	☐	Poor posture
☐	☐	☐	Sciatica
☐	☐	☐	Spinal Curvature

O	F	C	
			GASTRO-INTESTINAL
☐	☐	☐	Belching or gas
☐	☐	☐	Colitis/IBS
☐	☐	☐	Constipation
☐	☐	☐	Diarrhea
☐	☐	☐	Distension of abdomen
☐	☐	☐	Gall bladder trouble
☐	☐	☐	Jaundice
☐	☐	☐	Liver trouble
☐	☐	☐	Nausea
☐	☐	☐	Pain over stomach
☐	☐	☐	Poor appetite
☐	☐	☐	Vomiting
☐	☐	☐	Vomiting of blood
			EYES, EARS, NOSE &THROAT
☐	☐	☐	Asthma
☐	☐	☐	Colds
☐	☐	☐	Deafness
☐	☐	☐	Earache
☐	☐	☐	Ear discharge
☐	☐	☐	Enlarged glands
☐	☐	☐	Enlarged thyroid
☐	☐	☐	Failing vision
☐	☐	☐	Hay fever
☐	☐	☐	Nasal obstruction
☐	☐	☐	Nosebleeds
☐	☐	☐	Sinus infection
☐	☐	☐	Sore throat
☐	☐	☐	Tonsillitis
			RESPIRATORY
☐	☐	☐	Chest pain
☐	☐	☐	Chronic cough
☐	☐	☐	Difficult breathing
☐	☐	☐	Wheezing

O	F	C	
			CARDIO-VASCULAR
☐	☐	☐	Hardening of arteries
☐	☐	☐	High blood pressure
☐	☐	☐	Low blood pressure
☐	☐	☐	Pain over heart
☐	☐	☐	Poor circulation
☐	☐	☐	Rapid heart beat
☐	☐	☐	Slow heart beat
☐	☐	☐	Swelling of ankles
			SKIN
☐	☐	☐	Boils
☐	☐	☐	Bruise easily
☐	☐	☐	Hives or allergy
☐	☐	☐	Itching
☐	☐	☐	Varicose veins
			GENITO-UNRINARY
☐	☐	☐	Bed-wetting
☐	☐	☐	Blood in urine
☐	☐	☐	Frequent urination
☐	☐	☐	Inability to control kidneys
☐	☐	☐	Kidney infection or stones
☐	☐	☐	Painful urination
☐	☐	☐	Prostate trouble
			FOR WOMEN ONLY
☐	☐	☐	Cramps or backache
☐	☐	☐	Excessive menstrual flow
☐	☐	☐	Hot flashes
☐	☐	☐	Irregular cycle
☐	☐	☐	Menopausal symptoms
☐	☐	☐	Painful menstruation
☐	☐	☐	Vaginal discharge

☐ Yes ☐ No Are you pregnant?

CHECK THE FOLLOWING CONDITION YOU HAVE HAD:

- ☐ Alcoholism
- ☐ Anemia
- ☐ Appendicitis
- ☐ Arteriosclerosis
- ☐ Arthritis
- ☐ Polio
- ☐ Cancer
- ☐ Diabetes
- ☐ Eczema
- ☐ Emphysema
- ☐ Epilepsy
- ☐ Gout
- ☐ Heart disease
- ☐ Lumbago
- ☐ Multiple sclerosis
- ☐ Pleurisy
- ☐ Rheumatic fever
- ☐ Scarlet fever
- ☐ Stroke
- ☐ Tuberculosis
- ☐ Ulcers
- ☐ Whooping cough

PLEASE PRINT

List surgical operation and when: _____

Drugs you now take: ☐ Anti-inflammatories ☐ Pain killers ☐ Muscle relaxers ☐ Other _____
☐ Cholesterol pills ☐ Blood pressure pills ☐ Birth control pills

Are you wearing: ☐ Heal lifts ☐ Sole lifts ☐ Inner soles ☐ Arch supports

IN CASE OF EMERGENCY: (friend or relative) Name _____ Phone _____

AUTHORIZATION, ASSIGNMENT & RELEASE FORM

AUTHORIZATION AND ASSIGNMENT

In consideration of your undertaking to care from me, I agree to the following:

1. You are authorized to release any information you deem appropriate concerning my physical condition to any insurance company, attorney, or adjuster in order to process any claim for reimbursement of charges you incurred.

2. I authorize the direct payment to you of any sum I now or hereafter owe you, by my attorney out the proceeds of any settlement of my case, and/or by any insurance company obligated to make payment to me or you, based in whole or in part upon the charges made for your services.

3. In the event any insurance company obligated, by contractual agreement, to make payment to me or to you for the charges made for your services, refuses to make such payment upon demand by you. I herby assign and transfer to you the cause of action that exists in my favor against any such company (the name(s) of which is believed to be correctly set forth under pertinent date) and authorize you to prosecute and take action in my name as you see fit and further authorize you to compromise, settle or otherwise receive and claim as you see fit. However, it is understood that until a reasonable effort has been made to collect the sums due from the insurance company or companies contractually obligated, you will refrain from collecting the amounts owed directly from me. I understand that whatever amounts you do not collect from the insurance companies' proceeds, whether it is all or part of what is due, I personally owe and agree to pay to you.

4. In addition to the above, I herby waive the statute of limitations on collection and/or recovery in this State of Michigan.

5. I further agree that this Authorization and Assignment is irrevocable and ongoing until all monies owed are paid in full.

6. This Authorization and Assignment will be in continual effort until revoked by both parties.

_____ _____

Date Patient/Insured Signature

TERMS OF ACCEPTANCE

When a patient seeks Chiropractic health care and we accept a patient for such care, it is essential for both to be working towards the same objective. Chiropractic has only one goal. It is important that each patient understand both the objective and method that will be used to attain it. This will prevent any confusion or disappointment.

ADJUSTMENT

An adjustment is the specific application of forces to facilitate the body's correction of verterbral subluxation. Our chiropractic method of correction is by specific adjustments of the spine, using the Gonstead technique.

HEALTH

A state of optimal physical, mental, and social well-being, not merely the absence of disease or infirmity.

VERTERBAL SUBLUXATION

A misalignment of one or more of the 24 vertebra in the spinal column which causes alternation of nerve function and interference to the transmission of mental impulses, resulting in a lessening of the body's innate ability to be at it's maximum health potential.

We do not offer to diagnose or treat any disease or condition other than vertebral subluxation. However if during the course of a chiropractic spinal examination, we encounter non-chiropractic or unusual findings, we will advise you. If you desire advice, diagnosis or treatment for those findings, we will recommend that you seek the services of a health care provider who specializes in that area. Our only practice objective is to eliminate nerve interference, with a specific adjustment to correct vertebral subluxations.

_____ _____

Signature Date