WELCOME TO RAY CHIROPRACTIC

ACCOUNT#_____

"GENTLE CHIROPRACTIC CARE FOR THE WHOLE FAMILY"

First Name: _____ M.I. _____ Last Name: _____

Address: _____ City: _____ ZIP: _____

Soc. Sec. # _____ Gender: ☐ M ☐ F Marital Status: ☐ M ☐ S ☐ W ☐ D

Date of Birth: _____ Age: _____ Name of Spouse: _____

Phone (Check best #) ☐ Home: _____ Cell: _____ ☐ Work: _____

Emergency Contact Name: _____ Phone: _____

Your:

Occupation: _____ Employer: _____

Health Insurance: _____ ID # _____ Group # _____

Subscriber Name: _____ Date of Birth: _____ Soc Sec: _____

How did you hear about our office: _____ **Your E-MAIL** _____

Have you ever suffered from:	YES	NO		YES	NO		YES	NO
1. Dizziness	☐	☐	6. Arthritis	☐	☐	11. Nervousness	☐	☐
2. Backaches	☐	☐	7. Headaches	☐	☐	12. Sinus Trouble	☐	☐
3. Heart Trouble	☐	☐	8. Asthma	☐	☐	13. Anemia	☐	☐
4. Diabetes	☐	☐	9. Neuritis	☐	☐	14. Cancer	☐	☐
5. Tuberculosis	☐	☐	10. Digestive Disorders	☐	☐			

Other: _____

Purpose of this appointment: _____

Other Doctors seen for this Condition: _____

Have you been treated for any health condition by a physician in the last year? ☐ YES ☐ NO

Describe: _____

Date of last Physical Examination: _____

Remarks and additional information: _____

PAYMENT IS EXPECTED AT THE TIME OF VISIT

Are You Insured? ☐ YES ☐ NO Company: _____

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that the Ray Chiropractic 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 the Ray Chiropractic will be credited to my account on receipt. However, I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered me will be immediately due and payable.

Patient's Signature: _____ Date: _____

Parent or Guardian Signature: _____ Date: _____

As a courtesy, we ask that you turn off your cell phone.

E-MAIL is used **only** to confirm appointments or announce promotions.

IF YOURS IS AN AUTO INJURY PLEASE COMPLETE THE FOLLOWING QUESTIONS

Date of Accident: _____ Hour: _____ ☐ AM ☐ PM Location: _____

How did Accident Occur? ☐ Auto Collision ☐ On-the-Job Injury ☐ Other _____

In your own words describe how your accident happened: _____

_____

_____

Was there a police at time of accident? ☐ YES ☐ NO

Were you taken by ambulance? ☐ YES ☐ NO

Hospital Name:_____ City:_____ Days:_____ Released:_____

If auto accident, were you ☐ Driver ☐ Passenger ☐ Pedestrian

If auto collision, were you struck from ☐ Behind ☐ Right Side ☐ Left Side ☐ Front ☐ Auto was parked

Did your car strike the other(s) involved? ☐ YES ☐ NO

OR did the other car strike yours? ☐ YES ☐ NO ☐ UNDETERMINED

As a result of the accident, were traffic citations issued to you? ☐ YES ☐ NO

Did you have you seat belt on? ☐ YES ☐ NO

Did you lose consciousness? ☐ YES ☐ NO How long?_____

List the extent of the injuries as you know them: _____

_____

_____

Did you require post-accident hospitalization? ☐ YES ☐ NO

Check symptoms you have noticed since accident: (check all that apply)

☐ Headache	☐ Dizziness	☐ Light Bothers Eyes	☐ Diarrhea
☐ Neck Pain	☐ Head Seems Too Heavy	☐ Loss of Memory	☐ Feet Cold
☐ Neck Stiff	☐ Pins and Needles in Arms	☐ Ears Ring	☐ Hands Cold
☐ Sleeping Problems	☐ Pins and Needles in Legs	☐ Face Flushed	☐ Stomach Upset
☐ Back Pain	☐ Numbness in Fingers	☐ Buzzing in Ears	☐ Constipation
☐ Nervousness	☐ Numbness in Toes	☐ Loss of Balance	☐ Cold Sweats
☐ Tension	☐ Shortness of Breath	☐ Fainting	☐ Fever
☐ Irritability	☐ Fatigue	☐ Loss of Smell	☐ _____
☐ Chest Pain	☐ Depression	☐ Loss of Taste	☐ _____

Symptoms other than above: _____

Have you lost any days of work? ☐ YES ☐ NO Dates: _____

Insurance Companies involved:

My Company: _____

Company of person responsible for injuries: _____

Have you been contacted by an insurance adjuster or company representative regarding this claim? ☐ YES ☐ NO

Do you have an attorney that has advised you in this care? ☐ YES ☐ NO

Name: _____

Address: _____ Telephone: _____

Date: _____

AS A COURTESY, WE ASK THAT YOU TURN OFF YOUR CELL PHONE.