

ORIGINAL

Patient History

Are you seeing anyone else for other problems or health conditions?  Yes  No

Please list the problem/s, date problem/s began, and Provider/s treating you for the condition/s:

Past health history

Have you...	Yes	No	If yes, include date & provider seen
...been diagnosed with Diabetes? Type I _____ or Type II _____	<input type="checkbox"/>	<input type="checkbox"/>	_____
...been treated for hypertension?	<input type="checkbox"/>	<input type="checkbox"/>	_____

Vitals

Height \_\_\_\_\_ Weight \_\_\_\_\_

Do you smoke?  Never  Former Smoker  Current/Every Day Smoker  Current Some Day Smoker

Medications

What medications are you currently taking? Include vitamins, herbs, minerals...

List Date Started, Brand Name, Generic Name, Strength, Dosage, Frequency, Duration, Quantity, Refills

Available, Prescribed by

Please be as specific as possible

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Do you have allergies?  Food  Environmental  Medication

List Type of Allergy and Reaction

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**Assignment & Release**

Insurance Information

I understand and agree that health and accident insurance policies are an agreement between an insurance carrier and myself. Furthermore, I understand that this office 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 this doctors office will be credited to my account upon 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 that if I suspend or terminate my care and treatment, any fees or outstanding balances for services I have received will be immediately due and payable.

Patient's/Parent's/Guardian's Signature: \_\_\_\_\_

Consent of Professional Services and Release of Information

I hereby authorize and release the doctor and whomever he/she may designate as his/her assistants, to administer treatment, physical examination, x-ray studies, laboratory procedures, chiropractic care or any clinic services that he/she deems necessary in my case; I furthermore authorize him/her to disclose all or any part of my patient record to any person or corporation which is or may be liable under a contract to this office or to the patient or to a family member or employer of the patient for all or part of the clinic's charge, including, and not limited to hospital or medical service companies, insurance companies, worker's compensation carriers, welfare funds, or the patient's employer.

Patient's/Parent's/Guardian's Signature: \_\_\_\_\_