



CONFIDENTIAL PATIENT INFORMATION

Date: _____

PERSONAL:

NAME _____ SEX _____ MARITAL STATUS _____ DATE OF BIRTH _____ AGE _____ HOME PHONE _____
(First and last name) (M or F) mo. day yr. (Area code) Number
ADDRESS _____ CITY _____ STATE _____ ZIP CODE _____
(Include street type, such as St., Ave., etc.)

Social Sec. # _____ Occupation _____ Company Name _____ Location _____ Business Phone Number _____

Spouse's First Name _____ Spouse's Soc. Sec. # _____ Spouse's Employer _____ Location _____

NAME OF NEAREST RELATIVE _____ PHONE _____

WHO REFERRED YOU TO OUR OFFICE? _____

IS YOUR VISIT DUE TO AN ACCIDENT? NO YES (If yes, please see receptionist for Injury Report)

PRESENT COMPLAINT _____

BRIEFLY DESCRIBE SYMPTOMS _____

LIST OTHER DOCTOR(S) SEEN FOR THIS CONDITION _____

HAVE YOU EVER HAD SAME OR SIMILAR CONDITION? NO YES (If yes, please describe) _____

DESCRIBE THE OPERATIONS YOU'VE HAD: _____ WHEN? _____

HAVE YOU BEEN TREATED BY A PHYSICIAN FOR ANY HEALTH CONDITION IN THE LAST YEAR? NO YES

DESCRIBE CONDITION: _____

DATE OF LAST PHYSICAL EXAM _____

ARE YOU NOW TAKING ANY MEDICATION? NO YES WHAT KIND? _____

ARE YOU ALLERGIC TO ANY MEDICATION? NO YES WHAT KIND? _____

ARE YOU PREGNANT? NO YES DATE OF LAST MENSTRUAL PERIOD _____

INSURANCE DATA (Clinic policy requires payment arrangements to be made on the first visit)

DO YOU HAVE INSURANCE? NO YES INS. COMPANY NAME _____

I.D. NO. _____ POLICY GROUP NO. _____

I UNDERSTAND AND AGREE THAT HEALTH AND ACCIDENT INSURANCE POLICIES ARE AN ARRANGEMENT 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 OFFICE WILL BE CREDITED TO MY ACCOUNT UPON RECEIPT. I PERMIT THIS OFFICE TO ENDORSE CO-INSURANCE REMITTANCES FOR THE CONVEYANCE OF CREDIT TO MY ACCOUNT, 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 UNDERSTAND THAT IF I SUSPEND OR TERMINATE MY CARE AND TREATMENT, ANY FEES FOR PROFESSIONAL SERVICES RENDERED ME WILL BE IMMEDIATELY DUE AND PAYABLE, UNLESS PRIOR ARRANGEMENT ARE MADE. I HEREBY AUTHORIZE THE DOCTORS AT YAKIMA/WEST VALLEY CHIROPRACTIC CENTRES AND WHOMEVER THEY MAY DESIGNATE TO ADMINISTER TREATMENT AS THEY SO DEEM NECESSARY AND ALSO AUTHORIZE THE RELEASE OF ANY INFORMATION ACQUIRE IN THE COURSE OF MY EXAMINATION OR TREATMENT. I AGREE TO PAY 1% PER MONTH (12% ANNUAL) INTEREST ON UNPAID BALANCES GREATER THAN 90 DAYS OLD. I CERTIFY THAT THE ABOVE INFORMATION IS TRUE AND CORRECT.

PATIENT'S SIGNATURE _____

PARENT'S OR GUARDIAN'S SIGNATURE _____

Medicare Lifetime Authorization

I request that payment of authorized Medicare benefits be made on my behalf to the Yakima/West Valley Chiropractic Centres for any services furnished to me by their physicians. I authorize the release of medical information about me to the CMS (Center for Medicare and Medicaid Services) and its agents any information needed to determine the benefits payable for services provided.

PATIENT'S SIGNATURE _____