Yakima • West Valley • Sunnyside
CHIROPRACTIC **Centres**

Yakima CHIROPRACTIC **Centres, Inc. P.S.**

CONFIDENTIAL PATIENT INFORMATION

Date:_____

PERSONAL:

NAME_____ (First and last name) SEX _____ (M or F) MARITAL STATUS _____ DATE OF BIRTH _____ (mo. day yr.) AGE _____ HOME PHONE_____ (Area code) (Number)

ADDRESS_____ (Include street type, such as St., Ave., etc.) CITY_____ STATE ____ ZIP CODE_____ CELL PHONE _____

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

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

E-MAIL _____ CAN WE PUT YOU ON OUR MAILING LIST? ❑ YES ❑ NO

NAME OF NEAREST RELATIVE _____ PHONE _____

WHO REFERRED YOU TO OUR OFFICE? _____

IS YOUR VISIT DUE TO AN AUTO ACCIDENT OR WORK INJURY? ❑ YES ❑ NO (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? ❑ YES ❑ NO (If yes, please describe) _____

_____

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

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

DESCRIBE CONDITION: _____

DATE OF LAST PHYSICAL EXAM _____

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

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

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

DO YOU HAVE INSURANCE? ❑ YES ❑ NO COMPANY _____

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. 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 to me will be immediately due and payable, unless prior arrangements are made. I hereby authorize the doctors at Yakima/West Valley/Sunnyside Chiropractic Centres and whomever they may designate to administer treatment as they so deem necessary. 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/Sunnyside 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