

APPLICATION FOR TREATMENT

Patient # _____

Date: _____

PLEASE WRITE LEGIBLY

Full Name: _____ Date of Birth: _____

Address: _____ Apt# _____ City _____

State _____ Zip Code _____ SSN: _____

Hm#: _____ Cell#: _____ Wk#: _____ Emergency Contact #: _____

Employer Name: _____ Is this a work-related injury? yes no

Check if you are: married single divorced separated other MALE FEMALE

Name of Insured: _____ Employer Name: _____

Insured's SSN: _____ Office Phone: _____

Referred to office by: Yellow Pages TV Publication- Which One _____

Billboard Sign Person-Name _____

HOW PAYMENT WILL BE MADE:

() Cash () Check () Workers' Comp. () Credit Card () Health Insurance () Auto Insurance

Name of Insurance Company _____ ID/Policy/Claim# _____

Address _____

Are you covered by more than one insurance company? () Yes () No

If yes, Name of Insurance Co. _____ ID/Policy/Claim# _____

Address _____

SUBJECTIVE COMPLAINTS

Explain **WHEN** and **HOW** your health problem occurred: _____

SYMPTOMS/COMPLAINTS: Come and go Are constant Came on over time Came on quickly

Symptoms have persisted for: Hours 1Day Days Weeks Months Years

Symptoms developed from: Work injury Auto accident Injury other than work or an auto accident

Gradual onset Illness Unknown cause

DESCRIBE AND MARK ON ILLUSTRATION THE AREAS OF COMPLAINT

PLEASE BE SPECIFIC

Involving Head & Neck: _____

Involving Mid-Back/Shoulders/Arms/Hands: _____

Involving Low-Back/Hips/Legs/Feet: _____

OTHER AREAS

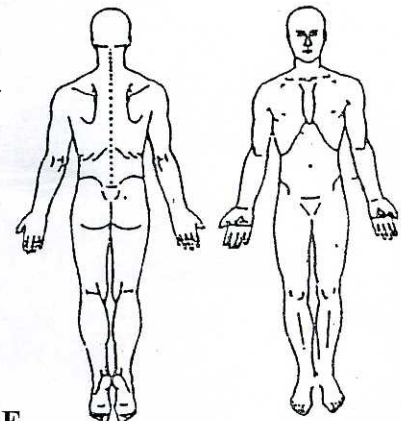
What activities make condition **WORSE**? _____

What activities make condition **BETTER**? _____

Have you ever had this condition/problem before? Yes No

If yes, when? _____

(WOMEN ONLY) Are you pregnant? Yes No



PATIENT AGREEMENT, ASSIGNMENT AND RELEASE

I, the undersigned, have insurance coverage with _____ and assign directly to Dr. _____ all medical benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions.

Signature of Insured/Guardian _____

_____ Date