Welcome To Our Office

Patient Name **Chart #** **Date**

PERSONAL INFORMATION

Social Security # _____-_____-_____ Date of Birth _____/_____/_____ Age_____ Male / Female

Marital Status: S M D W Spouse's Name_____

Address_____ City_____ State_____ Zip Code_____

Home Phone (_____)_____-_____ Cell Phone (_____)_____-_____

(if applicable)

Alternate Address_____ City _____ State _____ Zip Code _____

E-mail Address _____ @ _____

Please Note – We use a 3rd-party company for apointment reminders and other office related communication. Your information will not be sold or given out to anyone else.

Employment Status: Retired / Full-time / Part-time / Not employed Work Phone (_____)_____-_____

Employer_____ Occupation_____

Employer Address_____

In Case of an Emergency, Contact _____ Relationship _____

Phone Number ( )_____-_____

Referred By _____

BILLING INFORMATION

Cash / Check / Visa / MasterCard / Discover / CareCredit

(Payment is due at the time of treatment unless prior arrangements have been made)

☐ **Medicare**

(Please proved a copy of your insurance card)

☐ **Health Insurance** (Please provide a copy of your insurance card)

Insurance Co. _____

ID # _____ Group # _____

Policyholder's Name _____

Date of Birth _____/_____/_____

☐ **Attorney**

Name _____ Phone Number (_____)_____-_____

Address_____

☐ **Worker's Compensation**

Insurance Co._____

Address _____

Phone Number (_____)_____-_____ Ext. _____

Adjuster _____

Claim # _____

☐ **3rd Party Insurance** (Other car's insurance)

Insurance Co._____

Address _____

Phone Number (_____)_____-_____ Ext. _____

Adjuster _____

Claim # _____

☐ **Med Pay** (Your auto insurance)

Insurance Co._____

Address _____

Phone Number (_____)_____-_____ Ext. _____

Adjuster _____

Claim # _____

I hereby state that the information that I have provided this office is true and correct to the best of my knowledge.

I hereby authorize the performance upon myself of chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy and/or diagnostic x-rays of me performed by or under the direction of **Richard S Ray, DC**. I also give consent to the performance of other diagnostic and therapeutic procedures in addition to or different from those stated above, whether or not arising from presently unforeseen conditions, that the above-named doctor, associates, or assistants, may consider necessary or advisable in the course of my health care. I have or will have the opportunity to discuss with the doctor or with the assistants the nature and purpose of chiropractic adjustment and other procedures. I acknowledge that no guarantee or assurance of results that may be obtained from the procedure has been given by the above-named doctor, his associates or assistants.

I authorize **Ray Chiropractic Center, PLLC** to furnish complete information to my insurance carrier and to submit a claim for all services rendered by this office. I authorize and assign my insurance carrier or its intermediaries to issue payment checks directly to this office for services rendered until further notice.

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that **Ray Chiropractic Center, PLLC** will prepare any necessary reports and/or forms needed to assist me in making collection from the insurance company and that any amount authorized to be paid directly to **Ray Chiropractic Center, PLLC** will be credited to my account upon receipt. However, I clearly understand and agree that all services rendered me are charged directly to me and ultimately I am personally responsible for payment.

I understand that if I suspend or terminate my care/treatment, any fees for professional services rendered to me will be immediately due and payable. I understand that if applicable a county lein may be filed in an attempt to receive payment for services if a 3rd party is involved. If it is ever necessary for this office to employ collection counsel, I understand that I am fully responsible for any collection charges.

Patient Signature _____ **Date** _____

Health History

Patient Name _____ Date _____

Please answer the following as completely and accurately as possible – Thank you.

I EXERCISE

I am ☐ Right-handed ☐ Left-handed

☐ I am **NOT** pregnant ☐ I **AM** _____ weeks pregnant. My expected due date is ____/____/_____

☐ Never ☐ Occasionally ☐ Frequently ☐ Regularly

I USE TOBACCO

☐ Never ☐ Quit ____/____/_____ ☐ Yes (Cigarettes _____/ day / Cigars / Pipe / Chew / Other)

I DRINK ALCOHOL

☐ Never ☐ Socially ☐ Occasionally ☐ Frequently ☐ Regularly

FAMILY HISTORY

This is your FAMILY history (NOT including yourself)

Please note which family member is affected

Father ☐ Alive - Age _____ / ☐ Deceased - Age at Death _____ - Cause of Death _____

Mother ☐ Alive - Age _____ / ☐ Deceased - Age at Death _____ - Cause of Death _____

Brothers _____ Alive / _____ Deceased **Sisters** _____ Alive / _____Deceased **Children** _____ Alive / _____ Deceased

☐ Respiratory Disease / Asthma _____ ☐ Neurological Disease (Ex. Alzheimers, Parkinsons, MS) _____

☐ Hypertension / High Blood Pressure _____ ☐ Arthritis _____

☐ Gastrointestinal Disease / Genital Urinary _____ ☐ Stroke _____

☐ Diabetes _____ ☐ Cancer (Type _____) _____

☐ Skin Disease _____ ☐ Heart Disease / Heart Attack _____

☐ Other _____

PERSONAL HISTORY

☐ Hypertension / High Blood Pressure ☐ Arthritic Disease

☐ HEENT Disease (Ear, Nose, Throat) ☐ Cancer _____

☐ GI / GU Disease ☐ Endocrine Disease (Hormones)

☐ Major Accident _____ ☐ Allergies _____

☐ Neurological Disease _____ ☐ NO KNOWN ALLERGIES TO MEDICATIONS

DIAGNOSTICS

☐ X-Rays Lumbar ___/___/_____ Cervical ___/___/_____ Other _____ ___/___/_____

☐ MRI Lumbar ___/___/_____ Cervical ___/___/_____ Other _____ ___/___/_____

☐ CT Scan Lumbar ___/___/_____ Cervical ___/___/_____ Other _____ ___/___/_____

☐ Bone Scan ☐ Diagnostic Ultrasound

☐ Nerve Conduction Test (NCV) ☐ Doppler Ultrasound

☐ EMG ☐ Other _____

SURGICAL HISTORY

_____ Date ___/___/_____

_____ Date ___/___/_____

_____ Date ___/___/_____

** **DO YOU HAVE A PACEMAKER?** ☐ No ☐ Yes

** **DO YOU HAVE ANY SURGICAL PINS / PLATES / SCREWS?** ☐ No ☐ Yes _____

MEDICATION

Name	Reason	Dose	Times / day

** **ARE ANY OF THE ABOVE MEDICATIONS A BLOOD THINNER ?** ☐ No ☐ Yes

Patient Signature _____ **Date** _____

For Office Use Only

Height Ft In **Weight** lbs **Right BP** / **Left BP** / **Pulse** bpm **Resp** pm