

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 appointment 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)

Health Insurance (Please provide a copy of your insurance card)
 Insurance Co. _____
 ID # _____ Group # _____
 Policyholder's Name _____
 Date of Birth ____/____/____

Medicare
 (Please provide a copy of your insurance card)

Attorney
 Name _____ Phone Number (____) _____ - _____
 Address _____

<input type="checkbox"/> Worker's Compensation	<input type="checkbox"/> 3rd Party Insurance (Other car's insurance)	<input type="checkbox"/> Med Pay (Your auto insurance)
Insurance Co. _____	Insurance Co. _____	
Address _____	Address _____	
Phone Number (____) _____ - _____ Ext. _____	Phone Number (____) _____ - _____ Ext. _____	
Adjuster _____	Adjuster _____	
Claim # _____	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.

<p>I EXERCISE</p> <p>I USE TOBACCO</p> <p>I DRINK ALCOHOL</p>	<p>I am <input type="checkbox"/> Right-handed <input type="checkbox"/> Left-handed</p> <p><input type="checkbox"/> I am NOT pregnant <input type="checkbox"/> I AM _____ weeks pregnant. My expected due date is ____ / ____ / ____</p> <p><input type="checkbox"/> Never <input type="checkbox"/> Occasionally <input type="checkbox"/> Frequently <input type="checkbox"/> Regularly</p> <p><input type="checkbox"/> Never <input type="checkbox"/> Quit ____ / ____ / ____ <input type="checkbox"/> Yes (Cigarettes ____ / day / Cigars / Pipe / Chew / Other)</p> <p><input type="checkbox"/> Never <input type="checkbox"/> Socially <input type="checkbox"/> Occasionally <input type="checkbox"/> Frequently <input type="checkbox"/> Regularly</p>
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<p>FAMILY HISTORY</p> <p>This is your <u>FAMILY</u> history (NOT including yourself)</p> <p>Please note which family member is affected</p>	<p>Father <input type="checkbox"/> Alive - Age ____ / ____ / ____ <input type="checkbox"/> Deceased - Age at Death ____ - Cause of Death _____</p> <p>Mother <input type="checkbox"/> Alive - Age ____ / ____ / ____ <input type="checkbox"/> Deceased - Age at Death ____ - Cause of Death _____</p> <p>Brothers ____ Alive / ____ Deceased Sisters ____ Alive / ____ Deceased Children ____ Alive / ____ Deceased</p> <p><input type="checkbox"/> Respiratory Disease / Asthma _____ <input type="checkbox"/> Neurological Disease (Ex. Alzheimers, Parkinsons, MS) _____</p> <p><input type="checkbox"/> Hypertension / High Blood Pressure _____ <input type="checkbox"/> Arthritis _____</p> <p><input type="checkbox"/> Gastrointestinal Disease / Genital Urinary _____ <input type="checkbox"/> Stroke _____</p> <p><input type="checkbox"/> Diabetes _____ <input type="checkbox"/> Cancer (Type _____) _____</p> <p><input type="checkbox"/> Skin Disease _____ <input type="checkbox"/> Heart Disease / Heart Attack _____</p> <p><input type="checkbox"/> Other _____</p>
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<p>PERSONAL HISTORY</p>	<p><input type="checkbox"/> Hypertension / High Blood Pressure <input type="checkbox"/> Arthritic Disease</p> <p><input type="checkbox"/> HEENT Disease (Ear, Nose, Throat) <input type="checkbox"/> Cancer _____</p> <p><input type="checkbox"/> GI / GU Disease <input type="checkbox"/> Endocrine Disease (Hormones)</p> <p><input type="checkbox"/> Major Accident _____ <input type="checkbox"/> Allergies _____</p> <p><input type="checkbox"/> Neurological Disease _____ <input type="checkbox"/> NO KNOWN ALLERGIES TO MEDICATIONS</p>
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<p>DIAGNOSTICS</p>	<p><input type="checkbox"/> X-Rays Lumbar ____ / ____ / ____ Cervical ____ / ____ / ____ Other ____ / ____ / ____</p> <p><input type="checkbox"/> MRI Lumbar ____ / ____ / ____ Cervical ____ / ____ / ____ Other ____ / ____ / ____</p> <p><input type="checkbox"/> CT Scan Lumbar ____ / ____ / ____ Cervical ____ / ____ / ____ Other ____ / ____ / ____</p> <p><input type="checkbox"/> Bone Scan <input type="checkbox"/> Diagnostic Ultrasound</p> <p><input type="checkbox"/> Nerve Conduction Test (NCV) <input type="checkbox"/> Doppler Ultrasound</p> <p><input type="checkbox"/> EMG <input type="checkbox"/> Other _____</p>
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<p>SURGICAL HISTORY</p>	<p>_____ Date ____ / ____ / ____</p> <p>_____ Date ____ / ____ / ____</p> <p>_____ Date ____ / ____ / ____</p> <p>** DO YOU HAVE A PACEMAKER? <input type="checkbox"/> No <input type="checkbox"/> Yes</p> <p>** DO YOU HAVE ANY SURGICAL PINS / PLATES / SCREWS? <input type="checkbox"/> No <input type="checkbox"/> Yes _____</p>
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<p>MEDICATION</p>	<table style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="width: 35%;">Name</th> <th style="width: 35%;">Reason</th> <th style="width: 15%;">Dose</th> <th style="width: 15%;">Times / day</th> </tr> </thead> <tbody> <tr> <td>_____</td> <td>_____</td> <td>_____</td> <td>_____</td> </tr> <tr> <td>_____</td> <td>_____</td> <td>_____</td> <td>_____</td> </tr> <tr> <td>_____</td> <td>_____</td> <td>_____</td> <td>_____</td> </tr> <tr> <td>_____</td> <td>_____</td> <td>_____</td> <td>_____</td> </tr> </tbody> </table> <p>** ARE ANY OF THE ABOVE MEDICATIONS A BLOOD THINNER? <input type="checkbox"/> No <input type="checkbox"/> Yes</p>	Name	Reason	Dose	Times / day	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____
Name	Reason	Dose	Times / day																		
_____	_____	_____	_____																		
_____	_____	_____	_____																		
_____	_____	_____	_____																		
_____	_____	_____	_____																		

Patient Signature _____ **Date** _____

For Office Use Only

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

