Yakima • West Valley 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_____

_____

Social Sec. # Occupation Company Name Location Business Phone Number

_____

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

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

NAME OF NEAREST RELATIVE _____ PHONE _____

WHO REFERRED YOU TO OUR OFFICE? ❑Patient who_____Web site, ❑Insurance, ❑Location, ❑Yellow Pages, ❑Other_____

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 SIMUILAR 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 IS THE LAST YEAR? ❑ NO ❑ YES

DESCRIBE CONDITION: _____

DATE OF LAST PHYSICAL EXAM _____

ARE YOU NOW TAKING 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. # _____ GROUP # _____

DO YOU HAVE 2nd INSURANCE? ❑NO ❑YES INS. COMPANY NAME _____, I.D. # _____ GROUP # _____

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 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. I agree to pay 1% (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 _____