PATIENT INFORMATION

Last Name ___________________________________ First Name ____________________ M _____ Nickname ____________________

(Please Circle) Sex: Male Female Martial Status: Single Married Separated Divorced Widowed

Date of Birth ____________________ Age _____ SS# ________________________ Email _______________________________

Mailing Address ____ City/State ________________________________ Zip __________

Physical Address ____ City/State _______________________________ Zip __________

Home Phone ( ) _____________ Cell Phone ( ) __________________________ Work Phone ( ) _____________________

Employer ____Occupation ____

Employer Address ____ City/State _______________________________ Zip _________

IF PATIENT IS A MINOR, PLEASE COMPLETE THE FOLLOWING SECTION:

Legal Guardian ____ Relationship to patient: _________________

Home address (if different than above) ____ Phone _______________

SS# ___________________________ Employer Name & Address ____

____Employer Phone ____________________________

PLEASE GIVE THE RECPTIONIST YOUR DRIVER'S LICENSE AND INSURANCE CARD TO COPY UPON ARRIVAL.

IF THIS IS DUE TO AN ACCIDENT, COMPLETE THE FOLLOWING

Date of Accident ____________________ Auto _________ Work ________ Slip & Fall ________ Other _______________

Attorney Name ____

Insurance Company (Work Medpay PIP) ____

Address ____ Phone _______________________

Claim # _______________________ Adjuster ____________________________________ Insured _______________________________

IF THIS VISIT IS AUTO ACCIDENT RELATED, PLEASE GIVE THE RECEPTIONIST YOUR AUTOMOBILE INSURANCE CARD TO COPY.

How did you hear about us? Times-Picayune Pelican Pages Sunshine Pages Other*

If other, please explain (for example: another patient referral, ad, insurance directory) ____

I certify all information is true and correct. I hereby authorize the release of any information by this office in accordance with the Health Insurance Portability and Accountability Act of 1996 (HIPPA). I also assign my benefits payments to be made directly to Performance Chiropractic Clinic/ Advanced Medical Rehab. I understand I am financially responsible for all services rendered, if my account becomes 30 days overdue, it will be subject to a 1.5% per month finance charge. If I fail to pay as promised, I understand outside collection services may be necessary and I agree to pay any and all reasonable costs and attorney/collection agency fees.

____ ____________________

PATIENT SIGNATURE OR LEGAL GUARDIAN SIGNATURE **DATE**

PLEASE INDICATE PAIN AND NUMBNESS ON THE DRAWINGS

Have you ever had chiropractic care before? YES NO If yes, where ______________________________

List your chief complaints in order of severity:

1. ______________________ For how long? ______________________
2. ______________________ For how long? ______________________
3. ______________________ For how long? ______________________
4. ______________________ For how long? ______________________

Which pain or problem do you want the doctor to resolve first? ______________________________

____

When and how did it begin? ______________________________

____

What makes it worse? ______________________________

____

How does it interfere with your life? ______________________________

____

PLEASE SELECT THE TYPE OF CARE DESIRED so we can provide you with the best treatment and management of your condition.

RELIEF CARE __________ CORRECTIVE CARE __________ COMPREHENSIVE CARE __________

I WOULD LIKE TO KNOW WHAT THE DOCTOR THINKS IS BEST FOR ME. __________