

INSURANCE INFORMATION

DATE: _____

Please **print** all information as clearly as possible. Please fill out this form **completely**. All of this information is necessary to complete your patient record and to properly file your insurance claims.

First Name (no nicknames) _____ M.I. _____ Last Name _____

Sex: M F Birth Date ____/____/____ Age _____ Social Security (required) ____/____/____

Marital Status: S M D/S W Spouse's Name _____

Perm Address: _____ City: _____ State: _____ Zip: _____

Temp Address: _____ City: _____ State: _____ Zip: _____

Home Phone: () _____ - _____ Work Phone: () _____ - _____ Cell Phone: () _____ - _____

Employment Status: () Full Time () Part Time () Student () Homemaker () Unemployed () Retired

Employer (required): _____ Occupation: _____

Family Doctor: _____ Would you like us to send a Report to your family physician? Y N

Emergency Contact: Name: _____ Phone: () _____ - _____
Relationship: Spouse Parent Child Other: _____

E-Mail Address: (for patient newsletter) _____ @ _____ . _____

How were you Referred? : () Physician () Friend/Relative () Yellow Pages () Newsletter () Mailer

Whom may we thank for referring you to our office? _____

Cause of Complaint: () Auto Accident () Work Injury () Other Accident () Illness () Unknown

Primary Insurance

Insurance Company Full Name: _____

Policy ID #: _____ Group #: _____

Relationship to Insured: () Self () Spouse () Child () Step Child () Parent () Other: _____

Insured's First Name: _____ M.I.: _____ Last: _____

Insured's Birth date: ____/____/____ Insured's Social Security # (required): ____ - ____ - ____

Insured's Employer: _____ Work Phone: () _____ - _____

Secondary Insurance

Insurance Company Full Name: _____

Policy ID #: _____ Group #: _____

Relationship to Insured: () Self () Spouse () Child () Step Child () Parent () Other: _____

Insured's First Name: _____ M.I.: _____ Last: _____

Insured's Birth date: ____/____/____ Insured's Social Security # (required): ____ - ____ - ____

Insured's Employer: _____ Work Phone: () _____ - _____

Chiropractic Treatment Options:

- **Relief Care Option**

This first treatment option is designed to **PATCH UP** your health problems. The goal of this treatment phase is to just get you out of pain as quickly as possible. It is similar to placing a band-aid on your health problem for temporary relief of your symptoms. Treatment during this phase usually takes 6 to 12 visits over a period of two to four weeks depending upon the severity of your condition.

- **Corrective Care Option**

This second treatment option is designed to try to **FIX** your health problems (or to get it to as near normal as possible). This treatment option offers longer lasting results and depending upon the severity of your problem, it can take up to four to twelve weeks to correct.

- **Exercise Programs**

We offer two exercise programs that are specifically designed for your condition and supervised by our Physical Therapy Department. These exercise programs consist of (3) twenty minute in-office sessions, a detailed instructional manual and equipment so you can continue to use the program at home.

- **Strength Program**

Specific exercise program designed to target and isolate the CORE muscles and their supporting structures. You will be given a Gym Ball and an instructional manual so you can continue the Program at home.

- **Flexibility Program**

Specific stretching program designed help lengthen those tight, shortened muscles. You will be given a Stretch Band and an instructional manual so you can continue the Program at home.

- **Wellness Care Option**

Once correction is achieved and your health problems have improved, you may choose to maintain this correction by receiving occasional periodic treatment.

I wish to choose all of the following options:

Relief Care **Corrective Care** **Exercise Programs** **Wellness Care**

We are currently offering a FREE Family Care Examination!

Most of our patients bring their Family in for Chiropractic care. If you would like to have your children and/or your Spouse checked for spinal misalignments, **please check the box below**. They can receive a complimentary examination if it is scheduled within 2 weeks of the start of your care. This exam is **no cost to you** and does not obligate them to receive future care.

Yes, I would like my family members examined. I will schedule the appointments with the Front Desk Receptionist. No, I am not interested.