

HEALTH HISTORY UPDATE

In order for us to best serve you, and so that we may bring your original health history up to date, please provide us with the following information. **PLEASE PRINT**

Name: _____ D.O.B. _____ Date: _____

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

Telephone (Home): _____ (Office): _____ E-mail: _____

1) Is your visit to this office in reference to an accident? Yes No

If Yes, was it: Work Comp Automobile Personal Injury Other _____

2) Please list any falls, surgery, and/or accidents since last visit: _____

3) Date of last Chiropractic adjustment: _____

4) Since your last office visit to this office, have you consulted another Doctor? Yes No

If so, please give the Doctor's name: _____
and condition for which you were treated: _____

5) What type of treatment / medication did you receive? _____

6) Any other information the Doctor should know regarding this condition or any other: _____

INSURANCE DATA: Office policy requires payment arrangements be made on first visit.

Name of persons responsible for payment: _____ Telephone: _____

Do you have insurance? Yes No Company: _____

Does your plan require prior authorization? Yes No

Please list all sources of insurance:

Group Insurance _____ Policy # _____ Contract # _____
Name

Spouse's Insurance _____ Policy # _____ Contract # _____
Name

Workers Compensation Carrier _____ Employer _____

Other _____

I understand and agree that if I have health and/or accident insurance, these policies are an arrangement between the insurance carrier and myself. Further, I understand that this health care provider **will/will not** prepare reports and forms to assist in reimbursement from the insurance company. Any amount authorized to be paid directly to this office will be credited to my account on receipt. However, I clearly understand and agree that all services rendered to me are my personal responsibility for payment. I also 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.

I hereby authorize the doctor to examine and treat my condition as he/she deems appropriate through the use of Chiropractic Health Care, and I give authority for these procedures to be performed. It is understood and agreed the amount paid to the Doctor for imaging is for examination only and the negative will remain the property of this office, being on file where they may be viewed.

Patient's Signature: _____ **Date:** _____

Guardian or Parents Signature Authorizing Care: _____ **Date:** _____