Alderwood Back & Neck Pain Clinic

Confidential Patient Information

Date:_____ Email:_____

Name:_____ Cell Phone:_____
First & Last Name

Sex:_____ D.O.B_____ Age:_____ Home Phone:_____
M or F Mo/Day/Yr.

Address:_____ City:_____ State:_____ Zip Code:_____
Include Street type & Apt. #

_____ _____ _____ _____
Social Security # Business Phone # Occupation Company Name & Location

_____ _____ _____
Spouse's First Name Occupation Spouse's Employer & Location

Name of nearest relative (not your spouse):_____ Phone:_____

How were you referred to our office?

Yellow Pages:___ Another Doctor- Who?_____ Attorney – Who?_____

Sign/Location:___ Friend or family – Who?_____ Internet: _____

Your Present Complaint(s)_____

BRIEFLY DESCRIBE YOUR SYMPTOMS_____

_____

List other doctor(s) seen for this condition:_____

Medical History: Please list any medical conditions you have had in the past:_____

_____

Describe any operations you've had and the dates:_____

Have you been treated by a physician for any heath conditions in the last year? YES___ NO___
Describe Condition:_____

Are you currently taking any medications? YES____ NO___ What kind?_____

Are you pregnant? YES__ NO___ Date of last menstrual period?_____

Do you have health insurance? YES___ NO___ Company:_____

I.D. # _____ Policy Group No._____

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that this office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to this office will be credited to my account upon receipt.
I permit this office to endorse co-issued 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. It is my understanding that my credit may be checked if Alderwood Back & Neck Pain Clinic extends credit to me and 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, unless prior arrangements are made. I hereby authorize that doctor's at Alderwood Back & Neck Pain Clinic and whomever they may designate as their assistants to administer treatment, as they so deem necessary and also authorized release of any information acquired in the course of my examination or treatment. I understand that 1% interest per month will be charged on any balance owing past 60 days. I certify that the above information is true and correct.

Patient's (Parent or Guardian's) signature:_____ Date:_____

I understand that by signing below I am stating that my Chiropractic payment and or deductible would be a financial hardship on me. My doctor has agreed to adjust part or all of my co payment and or deductible. I have signed this in the presence of my doctor and I authorize the Alderwood Back & Neck Pain Clinic to send this information to my insurance company.

Patient's (Parent or Guardian's) signature:_____ Date:_____