Lakes Family
CHIROPRACTIC, PA

Patient Information

Date_____

Name_____

Address_____

_____
City State Zip

Phone Number_____

Cell Number: _____

Email:_____

Sex: ❑M ❑F Age_____ Birthdate_____

Soc. Sec. Num._____

Occupation_____

Employer_____

Work Address_____

_____
City State Zip

Work Phone_____

Marital Status: ❑Single ❑Married

Spouse's Name_____

Spouse's Employer_____

How did you hear about us?_____

In Case of Emergency Contact

Name_____ Relationship_____

Phone_____

Insurance

Insured Member's Name_____

Insured Member's Birthdate_____

Soc. Sec. Num._____

Relationship to Patient_____

Insurance Company_____

ID#_____ Group#_____

Insurance Co. Phone_____

ASSIGNMENT AND RELEASE

I, the undersigned certify that I (or my dependent) have insurance coverage and assign directly to Lakes Family Chiropractic all insurance benefits, if any, otherwise payable to me for services rendered. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I understand that I am financially responsible for all charges whether or not paid by insurance. Any balance over 90 days will be assessed a 1.5% interest charge. I certify that the information on this form is true and correct to the best of my knowledge.

_____
Patient (Parent or Guardian) Signature

_____
Patient's Relationship to Insured Date

Accident Information

Is condition due to an accident? ❑Yes ❑No

Type of accident: ❑Auto ❑Work ❑Home ❑Other

To whom have you reported your accident?

❑Auto Insurance ❑Employer ❑Work Comp ❑Other

Attorney Name (if applicable)_____

Address_____

_____
City State Zip

Symptoms

Reason for visit _____

When did your symptoms appear? _____

Is this condition getting progressively worse? ❑Yes ❑No ❑Unknown

Type of pain: ❑Sharp ❑Dull ❑Throbbing ❑Numbness
❑Aching ❑Shooting ❑Burning ❑Tingling
❑Cramps ❑Stiffness ❑Swelling ❑Other

How bad: ❑Mild ❑Moderate ❑Severe

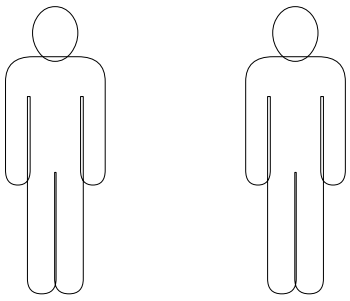
How often: ❑Occasional ❑Frequent ❑Constant

Pain interferes with: ❑Work ❑Sleep ❑Daily Routine ❑Recreation

Pain is aggravated by: ❑Sitting ❑Standing ❑Walking ❑Lying
❑Lifting ❑Reaching ❑Bending ❑Other

Please mark the location of your symptoms on the diagram below:

FRONT BACK



Health History

What treatment have you already received for your condition? ❑None ❑Surgery ❑Physical Therapy ❑Chiropractic ❑Medication ❑Other_____

Have you had any of the following:

AIDS/HIV	❑Yes ❑No	Depression	❑Yes ❑No	Miscarriage	❑Yes ❑No	Scarlet Fever	❑Yes ❑No
Alcoholism	❑Yes ❑No	Emphysema	❑Yes ❑No	Mononucleosis	❑Yes ❑No	Stroke	❑Yes ❑No
Allergies	❑Yes ❑No	Epilepsy	❑Yes ❑No	Multiple Sclerosis	❑Yes ❑No	Suicide Attempt	❑Yes ❑No
Anemia	❑Yes ❑No	Glaucoma	❑Yes ❑No	Mumps	❑Yes ❑No	Thyroid Problem	❑Yes ❑No
Anorexia	❑Yes ❑No	Goiter	❑Yes ❑No	Osteoporosis	❑Yes ❑No	Tonsillitis	❑Yes ❑No
Appendicitis	❑Yes ❑No	Gonorrhea	❑Yes ❑No	Pacemaker	❑Yes ❑No	Tuberculosis	❑Yes ❑No
Arthritis	❑Yes ❑No	Gout	❑Yes ❑No	Parkinson's Disease	❑Yes ❑No	Tumor	❑Yes ❑No
Asthma	❑Yes ❑No	Heart Disease	❑Yes ❑No	Pinched Nerve	❑Yes ❑No	Typhoid Fever	❑Yes ❑No
Bleeding Disorders	❑Yes ❑No	Hepatitis	❑Yes ❑No	Pneumonia	❑Yes ❑No	Ulcer	❑Yes ❑No
Breast Lump	❑Yes ❑No	Hernia	❑Yes ❑No	Polio	❑Yes ❑No	Vaginal Infection	❑Yes ❑No
Bronchitis	❑Yes ❑No	Herniated Disk	❑Yes ❑No	Prostate Problem	❑Yes ❑No	Venereal Disease	❑Yes ❑No
Bulimia	❑Yes ❑No	Herpes	❑Yes ❑No	Prosthesis	❑Yes ❑No	Whooping Cough	❑Yes ❑No
Cancer	❑Yes ❑No	High Cholesterol	❑Yes ❑No	Psychiatric Care	❑Yes ❑No	Other_____	
Cataracts	❑Yes ❑No	Kidney Disease	❑Yes ❑No	Rheumatoid Arthritis	❑Yes ❑No		
Chemical Dependency	❑Yes ❑No	Liver Disease	❑Yes ❑No	Rheumatic Fever	❑Yes ❑No		
Chicken Pox	❑Yes ❑No	Measles	❑Yes ❑No				
Diabetes	❑Yes ❑No	Migraine Headache	❑Yes ❑No				

Are you pregnant? ❑Yes ❑No Due Date_____

EXERCISE

❑Never
❑Occasional
❑Moderate
❑Excessive

WORK ACTIVITY

❑Sitting ❑Lifting
❑Standing ❑Light Labor
❑Driving ❑Heavy Labor
❑Computer ❑Other_____

HABITS

❑Smoking
❑Alcohol
❑Caffeine
❑High Stress

INJURIES/SURGERIES

❑Fall_____
❑Head Injury_____
❑Fracture_____
❑Surgery_____

Please list any medications you are currently taking_____

Consent for Treatment of a Minor

I hereby authorize Brian R. Carpenter, D.C. and whomever he may designate as his assistants, to administer treatment as he deems necessary to my child.

_____
Signature of Parent of Guardian Date

Payment Policy

For patients without insurance, we require payment for services the day that the services are rendered.

For patients with insurance coverage, we will be glad to submit a claim to your insurance company. Please provide your insurance card. 100% of your first day's charges are due at your first visit. Copays and/or co-insurance will be collected at the time of service. You will be responsible for any amount not covered by insurance.

For Auto Accident, Worker's Compensation and Personal Injury patients, please provide insurance company information and a claim number. We will be glad to submit a claim directly to the insurance company.

Our Commitment

Our commitment to you, during your chiropractic care program, is undivided and detailed clinical attention, professional and friendly service, superior chiropractic care, and a comfortable and healing environment for you and your family.

Welcome to
Lakes Family
CHIROPRACTIC, P.A.