

Name: _____
Date: _____
File #: _____



OHIO FAMILY & SPORTS CHIROPRACTIC

Patient Information

WELCOME! Please allow our staff to photocopy your driver's license and all available insurance cards.

PLEASE PRINT

Full Name: _____ Gender: M F Home Phone: _____

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

Age: _____ Birth Date: _____ Marital Status: _____ Number of Children: _____

Social Security #: _____ Driver's License #: _____

Employer: _____ Occupation: _____

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

Work Phone: _____ Cell Phone: _____ Email Address: _____

Do you have health insurance where you work? Yes No Plan/Group Number: _____

Insurance Company: _____ Policy Number: _____

Policy Holder Name: _____ Policy Holder Social Security #: _____

Your relationship to policy holder: Self Spouse Child Other _____

Name of Spouse, Parent, or Guardian: _____ Age: _____ Birth Date: _____ SSN: _____

Spouse's Phone: _____ Spouse's Email: _____

Who may we thank for referring you? _____

Is your condition due to an accident? Yes No Date of Accident: _____

Type of Accident: Auto Work Home Other _____

Person to contact in case of emergency: _____ Phone: _____

Name of Family Physician: _____ Phone: _____

May we update your family physician on your condition? Yes No

Acceptance of Financial Responsibility

I (we) agree to pay for services rendered to the above mentioned patient as the charge is incurred. I (we) understand that health and accident insurance policies are arrangements between an insurance carrier and myself and that I am personally responsible for payment of any and all services, covered or non-covered. If the doctor is a contracted provider for my managed care plan, I understand I am responsible for all co-payments and non-covered services. I also understand and agree to pay all copays and fees for non-covered services prior to seeing the doctor. I understand that if I terminate my care and treatment, any fees for professional services rendered me will be immediately due and payable.

I (we) authorize the doctor and his staff to release any information deemed appropriate concerning my physical condition to any insurance company, claims adjuster, case nurse, claims reviewer, employer, health care provider, or attorney in order to process any claim for reimbursement or charges incurred by me as a result of professional services rendered and hereby release him/her of any consequences thereof. I agree that a photostatic copy of this agreement shall serve as the original.

I (we) hereby authorize and direct payment of any medical/chiropractic expense benefits allowable to the doctor as payment toward the total charges for professional services rendered. This payment will not exceed my indebtedness to the assignee. I agree that a photostatic copy of this agreement shall serve as the original.

Patient's Signature: _____ Date: _____

Spouse's or Guardian's Signature: _____ Date: _____



Name: _____

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File #: _____

Child History

Age: _____ Gender: M F Race: _____

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Please check health complaints your child is currently experiencing or experiences on a recurring basis.

Asthma Headache Ear Infection Colic Allergies Bed Wetting Other _____

Please check any childhood disease your child has had:

Chicken Pox Measles Mumps Rubella Whooping Cough Ear Infection

Please comment on how often any of the above disease have occurred and when they occurred: _____

Is today's visit the result of an auto accident? Yes No If Yes, when? _____

Was your pregnancy normal? Yes No Explain: _____

Delivery: Home Hospital Medications: _____ Complications: _____

Which contact sports does your child participate in? Soccer Football Gymnastics Dance Hockey Baseball
 Wrestling Basketball Other _____

Is your child currently taking any medications: Yes No If Yes, which ones: _____

Has your child been immunized? Yes No If Yes, please list immunizations and age received: _____

List any surgeries or congenital conditions: _____

According to the National Safety Council, approximately 50% of infants fall head first from a high place (bed, changing table, etc.) during the first year of life. Has this happened to your child? Yes No If Yes, please explain: _____

Has your child experienced any serious accident or injury? Yes No If Yes, please explain: _____

Consent to Treatment of a Minor

I, being the lawful parent or guardian of _____, minor of the age of _____ do hereby give my consent, authorize, and request Ohio Family and Sports Chiropractic to administer such treatment deemed advisable, necessary, or requested on the above mentioned child.

Parent's signature _____ Date _____

Witness' signature _____ Date _____