

# SC **STONE CHIROPRACTIC**

*Building A Healthy Foundation*

PATIENT NAME: \_\_\_\_\_

CASE NO: \_\_\_\_\_

## **WELCOME**

The doctors and staff of Stone Chiropractic welcome you and want to provide you with the best possible care. We will conduct a thorough history and physical examination to decide if we can assist you. If we do not believe that your condition will respond to chiropractic care, we will not accept you as a patient but will refer you to another health care provider, if appropriate.

## **INSURANCE**

This office will process your insurance forms upon request. We will do our utmost to provide sufficient information to your carrier to obtain payment for your treatment. We have found that, in some instances, however, insurance companies will deny or reduce payment despite our best efforts to demonstrate the necessity for care. In the event that full payment is not made for any reason, you must understand that you are responsible to make payment in full.

## **PATIENT IDENTIFICATION**

|   |  |
|---|--|
| _____   | Name or Nickname I prefer to be called |
| Name _____  | in this office _____                   |
| _____   | Telephone (Home) _____                 |
| Street _____  | (Work) _____                           |
| _____   | Ok to call there? Yes ( ) No ( )       |
| City, State and Zip _____                             | _____                                  |
| _____   | Occupation _____                       |
| Social Security # _____                               | _____                                  |
| Male ( ) Female ( )                                   | Date of Birth _____ Age _____          |
| Contact in case of emergency, Name: _____             | _____                                  |
| Telephone # _____                                     | _____                                  |
| Name of Parent of Minor Patient (If applicable) _____ | _____                                  |

## **ACCEPTANCE AS PATIENT**

I understand and agree that the doctors of Stone Chiropractic have the right to refuse to accept me as a patient at any time before treatment begins. The taking of a history and the conducting of a physical examination are not considered treatment, but are part of the process of information gathering so that the doctor can determine whether to accept me as a patient.

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature

Please fill out the following form in as much detail as possible.

*Please print*

Cell # \_\_\_\_\_ E-mail Address \_\_\_\_\_

\_\_\_ Married \_\_\_ S \_\_\_ W \_\_\_ D # of Children \_\_\_ Name of Spouse \_\_\_\_\_

What brings you into the office today (please list your health challenge(s))?

\_\_\_\_\_  
\_\_\_\_\_

Have you ever had chiropractic care before? \_\_\_\_\_

For what problem? \_\_\_\_\_

Were the results satisfactory? Yes \_\_\_\_\_ No \_\_\_\_\_ N/A \_\_\_\_\_

Family physician's name \_\_\_\_\_

Do we have permission to send a report to your family physician? Yes \_\_\_\_\_ No \_\_\_\_\_

Will this case be covered by any insurance company? Major Medical \_\_\_\_\_ Auto \_\_\_\_\_

Blue Cross/Blue Shield \_\_\_\_\_ Workers' Compensation \_\_\_\_\_ Medicare \_\_\_\_\_

Other (Please list) \_\_\_\_\_

How did you find out about us? \_\_\_\_\_

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature