Geyer Springs CHIROPRACTIC and WELLNESS CENTER

patient form

7117 Geyer Springs Road ■ Little Rock, AR 72209 ■ 501-568-6612
www.geyerspringschiropractic.com

CONFIDENTIAL PATIENT INFORMATION

Welcome to our practice! Please complete all questions. Thank you.

Please Print

Name:			Date: / /
Address:			Home Phone:
City, State Zip:			Cell Phone:
Birth Date: / /	Age:	Sex: M F	Social Security #:
Marital Status: S M D W	Spouse's Name:		
Children's Names & Ages:			
Favorite Hobbies or Interests:			
Employed by:			Occupation:
Address:			Work Phone:
Who is financially responsible for this bill?			
Method of Payment: Cash	Check	Credit Card	Insurance

Current health complaints / reasons for consulting our office:

1. For how long?
2. For how long?
3. For how long?

Where is the pain?

Does the pain spread? □ Yes □ No If yes, where?

Do you have numbness? □ Yes □ No If yes, where?

Is there pain when you cough or sneeze? □ Yes □ No If yes, where?

Is there pain when you go from a sit to a stand? □ Yes □ No If yes, where?

Do you have any headaches? □ Yes □ No If yes, circle all that apply:

Tension Throb Sinus Migraine Other:

Indicate any function below that aggravates or is aggravated by your condition: (Circle all that apply)

Walking Step Climbing Driving Working Digestion Sleeping Recreation

Vision Bowel Movements Breathing Sinuses Hearing Smelling If female, Menstrual

Have you ever been to a chiropractor before? □ Yes □ No If yes, when?

List other doctors that were consulted for these conditions:

1. 2.

Previous diagnosis given:

List operations you have had:

1. 2. 3.

List serious illnesses you have had:

1. 2. 3.

Date of last physical examination: Is there any chance you are pregnant? □ Yes □ No

Have you ever been diagnosed with cancer? □ Yes □ No If yes, what kind?

Medication you currently take:

Parents, Siblings, or Children with similar problems? □ Yes □ No If yes, who:

OVER

CONFIDENTIAL PATIENT INFORMATION

Continued

*****HEALTH INSURANCE - Please allow our staff to photocopy your current health insurance card(s).*****

Insurance Company:	Phone #:
ID#:	Group #:

Who may we thank for referring you to our office? ____________________________________

Please read the following, then sign and date below.

1. I will allow this office to treat me, with other health care providers present, and to record my medical information, including consultation and examination, for documentation purposes, if necessary.
2. I give this office the right to use my name for any in office publications.
3. I acknowledge having the right to review and obtain a copy of the Notice of Privacy Practices of this office. (Once information is disclosed, it may not be protected by law.)
4. I authorize payment of medical benefits to this office.
5. I understand that I am responsible for any charges at Geyer Springs Chiropractic and billing of insurance is done as a courtesy, and any balance not collected from insurance is my responsibility.
6. I understand that Geyer Springs Chiropractic may not be a participating provider with my health insurance plan; therefore I may be financially liable for any uncovered services that are provided to me in this office.
7. In the event my account is turned over to an outside collection agency, additional fees (attorney's fees, court costs, etc.) will be added to my balance.
8. I authorize release of my medical records, for the purposes of diagnosis and treatment, to the above-mentioned physician / facility.
9. Authorization may be denied or retracted by notifying the Office Manager.

Patient's Signature: ______________________________ Date: ______________

Spouse's / Guardian's Signature: ______________________________ Date: ______________

(Authorization expires 1 year from signature date.)

OVER