

Patient Information required

Full Name: _____

I prefer to be called : _____

Age : _____ Birthdate : _____

Social Security # : _____

Address : _____

City: _____

State: _____ Zip: _____

Home Phone 1: _____

Work/ Daytime Phone 2: _____

E-mail address: _____

How did you hear about us? _____

Employer: _____

Occupation: _____

Work Address (city) : _____

Bank (name & city) : _____

Family Status: Single Married Divorced Widowed

If married:

Spouse name: _____

Work/ Daytime phone: _____

Employer: _____

Occupation: _____

Worker's Compensation (if applicable):

Name of Employer : _____

Claim # : _____

WC Administrator : _____

Address : _____

Phone # : _____

Privacy Policy

By signing, you acknowledge that you have read and understand our privacy policy.

Financial Policy and Authorizations

If your health insurance requires pre-authorization or referral, please be sure that you have taken care of this responsibility before our office performs billable services.

You are responsible for payment of all charges incurred at Performance Chiropractic. This responsibility extends to the total charges without regard to possible insurance benefits or determinations of necessity. Wellness treatments are not covered by or submitted to insurance.

You authorize Performance Chiropractic to request and/or release medical records to/from your insurance company and your referring and/or family physician.

We will file your insurance claims (if applicable) for you, and you authorize the assignment of all benefits to Performance Chiropractic.

You agree to pay any and all collection costs generated in the collection of payment for all charges incurred at Performance Chiropractic. If they become necessary, these collection costs include but are not limited to special postage expense, collection agency fees, attorney fees, and court costs.

Payment is expected at time services are rendered. We reserve the right to charge a \$50 missed appointment fee.

Your initials indicate that you have read, understand, and accept all terms:



Performance Chiropractic
1307 Jamestown Road; Suite 103, Williamsburg

New Patient Admin & Clinical
Updated: 07.30.08

Patient Signature _____ Print Name _____ Today's Date _____

If patient is under 18 years old, parent or guardian must sign : _____

Previous and Current Health Care

Include dates and doctors' names.

If not applicable, please write "none" or "N/A"

Family/primary care physician: _____

Please describe recent medical or other care:

Please describe previous chiropractic care:

Please describe any medications you take regularly (prescription or over the counter):

Please describe any surgery you have had, including dental and elective surgeries:

Please describe any injury you have had, including falls, car accidents, etc:

Please list your family medical history (diabetes, cancer, high blood pressure, stroke, heart attack, family diseases, etc.).

Indicate relationship (eg. parent, grandparent, sibling):

Please circle your current level of activity:

Regular Occasional None

Is your activity aerobic (raises your pulse for at least 20 minutes, 3 times/week)? Yes No N/A

Use of Smokeless Tobacco: ____/day

Use of Alcohol: ____drinks/day

Use of Caffeine : ____drinks/day

Do you currently smoke? Yes No

If yes, how many packs per day ?

<1 1 2 3>

For how many years ? _____

Have you quit smoking? Yes No

If yes, when did you quit ? _____

How many packs per day did you smoke ?

<1 1 2 3>

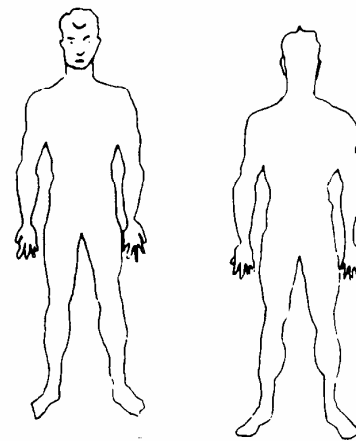
For how many years ? _____

Have you ever been a victim of abuse? Yes No

(This question allows us to be sensitive to your needs, and is intended to assist you in seeking appropriate resources if you have not yet done so.)

Current Areas of Concern

Please mark areas of concern on these diagrams:



Please list below the main complaints you have, in order of importance.

Describe pain: what & where How long?

- 1. _____
- 2. _____
- 3. _____
- 4. _____

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