PLEASE FILL THIS OUT COMPLETELY
PLEASE PRINT

Social Security No._____
Driver's License #_____
Date_____

CONFIDENTIAL PATIENT INFORMATION

Name_____ Home Phone_____
Address_____City_____ Zip Code_____
E-Mail Address_____ Cell Phone _____
Age____ Birth Date_____ Marital Status: M S W D How Many Children?_____
Occupation_____ Employer_____
Address_____ Office Phone_____
Insurance Company_____ Agents Name_____ Policy #_____
Name of Spouse_____ Spouse's Birth Date_____ Occupation_____
Employer_____ Office Phone_____
Patient's Nearest Relative_____ Address_____
Referred by_____
Date of Last Physical Examination_____

Have You Ever Suffered From:	YES	NO		YES	NO
1. Dizziness	☐	☐	8. Asthma	☐	☐
2. Backaches	☐	☐	9. Neuritis	☐	☐
3. Heart Trouble	☐	☐	10. Digestive Disorders	☐	☐
4. Diabetes	☐	☐	11. Nervousness	☐	☐
5. Tuberculosis	☐	☐	12. Sinus Trouble	☐	☐
6. Arthritis	☐	☐	13. Anemia	☐	☐
7. Headaches	☐	☐	14. Cancer	☐	☐

Purpose of this Appointment_____
Other Doctors seen for this Condition_____
Have you been treated for any health condition by a physician in the last year? _____
Describe:_____
Remarks and additional information:_____

PAYMENT IS EXPECTED AT THE TIME OF VISIT!

Name of Person Responsible for Payment:_____
Are You Insured? ☐ YES ☐ NO Company:_____

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that the Beals Clinic of Chiropractic will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to the Beals Clinic of Chiropractic will be credited to my account on receipt. However, I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any outstanding fees for professional services rendered me will be immediately due and payable, and will be charged to my visa, discover, or master card. If it is determined that the interest rate here in is unlawfully high, the parties agree that the excess above and beyond the legal rate shall be credited against the principle balance owed.

Credit Card: ☐ Visa ☐ Discover ☐ Master Card ID# (on back of card): _____

Credit Card #: _____ Expiration Date:_____
Delinquent accounts will be charged 18% Simple Annual Interest and/or all collection fees.

Patient's Signature:_____ Date:_____
Guardian or Spouse's Signature:_____ Date:_____
Information Taken By:_____ Date:_____

IF YOURS IS AN ACCIDENTAL INJURY PLEASE COMPLETE THE FOLLOWING QUESTIONS

Date of Accident:_____ Hour_____ Am__ Pm__ Location_____
How did Accident Occur? ☐Auto Collision ☐On-the-Job Injury ☐Other_____
If not an auto collision, please describe the circumstances:_____
_____
_____
Did you report the injury to your foreman or employer? ☐ YES ☐ NO
Did he (they) recommend care at our office? ☐ Yes ☐ NO
If auto accident, were you ☐ Driver ☐ Passenger ☐ Pedestrian
If auto collision, were you struck from ☐ Behind ☐ Right Side ☐ Left Side ☐ Front ☐ Auto was Parked
Did your car strike the other(s) involved? ☐ YES ☐ NO
OR did the other car strike yours? ☐ YES ☐ NO ☐ UNDETERMINED
As a result of the accident, were traffic citations issued to you? ☐ YES ☐ NO
To the driver of the other car? ☐ YES ☐ NO
To the driver of your car? ☐ YES ☐ NO
List the extent of the injuries as you know them_____
_____
_____
Did you require post-accident hospitalization? ☐ Yes ☐ No
Check symptoms you have noticed since accident:

☐Headache	☐Dizziness	☐Light Bother Eyes	☐Diarrhea
☐Neck Pain	☐Head Seems Too Heavy	☐Loss of Memory	☐Feet Cold
☐Neck Stiff	☐Pins and Needles in Arms	☐Ears Ring	☐Hands Cold
☐Sleeping Problems	☐Pins and Needles in Legs	☐Face Flushed	☐Stomach Upset
☐Back Pain	☐Numbness in Fingers	☐Buzzing in Ears	☐Constipation
☐Nervousness	☐Numbness in Toes	☐Loss of Balance	☐Cold Sweats
☐Tension	☐Shortness of Breath	☐Fainting	☐Fever
☐Irritability	☐Fatigue	☐Loss of Smell	☐_____
☐Chest Pain	☐Depression	☐Loss of Taste	☐_____

Symptoms other than above_____
Have you lost any days of work? ☐YES ☐NO Dates:_____
Insurance Companies involved:
My Company_____
Company of person responsible for injuries?_____
Have you been contacted by an insurance adjuster or company representative regarding this claim?
☐ YES ☐ NO
Do you have an attorney that has advised you in this care? ☐ YES ☐ NO

Name_____
Address_____ Telephone_____
Date_____