

Patient's Name \_\_\_\_\_

Date of Birth \_\_\_\_\_

# WELCOME

Thank you for selecting our healthcare team! We will strive to provide you with the best possible healthcare. To help us meet your entire healthcare needs, please fill out this form completely in ink. If you have any questions or need assistance, please ask us, we will be happy to help.

## 1. PERSONAL INFORMATION

Date \_\_\_\_\_ Birth date \_\_\_\_\_ Soc. Sec # \_\_\_\_\_

Last Name \_\_\_\_\_ First Name \_\_\_\_\_

Nickname \_\_\_\_\_ Gender: Male Female

Marital Status: Single Married Other Children \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Email address \_\_\_\_\_

Employer \_\_\_\_\_ Occupation \_\_\_\_\_

Employer's Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

How did you hear about us? \_\_\_\_\_

## 2. TELEPHONE

Home phone \_\_\_\_\_ Work Phone \_\_\_\_\_

Cell phone \_\_\_\_\_

Where do you prefer to receive your calls? Home Work Cell

What time of day is the best time to reach you? \_\_\_\_\_

In the event of an emergency, whom should we contact?

Name \_\_\_\_\_ Relationship \_\_\_\_\_ Phone # \_\_\_\_\_

## 3. CHIROPRACTIC INFORMATION

Describe your complaint.

How long have you had this condition? \_\_\_\_\_

Is it getting worse? \_\_\_\_\_

Have you seen a chiropractor before? If yes, how long?

\_\_\_\_\_

\_\_\_\_\_

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Are you currently under the care of a physician? Yes \_\_\_ No \_\_\_

If yes, for what? \_\_\_\_\_

Physician's Name \_\_\_\_\_ Group: \_\_\_\_\_

Address \_\_\_\_\_

\_\_\_\_\_ Telephone # \_\_\_/\_\_\_/\_\_\_

**4. FINANCIAL ARRANGEMENTS**

PAYMENT IS EXPECTED AT THE TIME OF EACH VISIT

Name of person responsible for payment: \_\_\_\_\_

Are you insured? Yes No Company: \_\_\_\_\_

For your convenience, we offer the following methods of payment:

Cash Check Master Card Visa Disc Amex

**5. INSURANCE INFORMATION**

Insured's Name \_\_\_\_\_ Relationship \_\_\_\_\_

Birth Date \_\_\_\_\_ Soc. Sec.# \_\_\_\_\_

Employer \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Occupation \_\_\_\_\_

Type: Health \_\_\_ Medicare \_\_\_ Auto \_\_\_ Work Comp. \_\_\_ PPO \_\_\_ HMO \_\_\_

Group # \_\_\_\_\_ Policy# \_\_\_\_\_

Insurance Co. \_\_\_\_\_

Insurance Co. Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

**SECONDARY INSURANCE**

Insured's Name \_\_\_\_\_ Relationship \_\_\_\_\_

Birth Date \_\_\_\_\_ Soc. Sec.# \_\_\_\_\_

Employer \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Occupation \_\_\_\_\_

Type: Health \_\_\_ Medicare \_\_\_ Auto \_\_\_ Work Comp. \_\_\_ PPO \_\_\_ HMO \_\_\_

Group # \_\_\_\_\_ Policy # \_\_\_\_\_

Insurance Co. \_\_\_\_\_

Insurance Co. Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Patient's Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

**Consent for Treatment of Minor**

I hereby authorize Dr. Michael A. Levinson, and whomever he may designate as his assistant(s), to perform diagnostic tests, including but not limited to, radiographs, and to administer treatment as he deems necessary to my child \_\_\_\_\_.

Parent Signature \_\_\_\_\_ Date \_\_\_\_\_

**CONSENT FOR TREATMENT**

I, the undersigned, hereby authorize Dr. Michael A. Levinson and whomever he may designate as his assistants to perform diagnostic tests, including but not limited to radiographs, and to administer treatment as is necessary.

I, also, certify that no guarantee or assurance has been made to the results that may be obtained.

Patient/Parent Signature \_\_\_\_\_ Date \_\_\_\_\_

**AUTHORIZATION AND RELEASE**

I authorize Dr. Michael A. Levinson, to release any information including the diagnosis and records of any treatment or examination rendered to my child or me during the period of such care to a third party payer and/or other health practitioners. I authorize and request my insurance company to pay directly to Dr. Levinson insurance benefits otherwise payable to me. I understand that my insurance carrier may pay less than the actual bill for services rendered. I agree to be responsible for payment of all services rendered on my behalf or that of my dependents.

X \_\_\_\_\_ Date \_\_\_\_\_

*Signature of patient or parent of minor*

**Authorization Release of Medical Information**

I \_\_\_\_\_, do hereby authorize you to release a copy of any and all information including x-rays, medical reports, clinical reports and other related documents acquired in the course of an examination and treatment.

Patient's Signature \_\_\_\_\_ Date \_\_\_\_\_

Patient's Name \_\_\_\_\_

Date of Birth \_\_\_\_\_

*PLEASE CIRCLE ANY OF THE FOLLOWING SYMPTOMS THAT YOU HAVE EXPERIENCED  
WITHIN THE PAST TWELVE MONTHS.*

Fevers  
Dizziness  
Tremors  
Seizure  
Blurry vision

Unintentionally changes  
Double Vision  
Memory loss Gait difficulty  
Difficulty concentrating  
Speech difficulty

Night sweats  
Weakness  
Back pain  
Swallowing difficulty  
Incontinence

Pain  
Facial weakness  
Depression  
MS  
Headaches

Facial pain  
Sleep problems  
Anxiety  
Dementia  
Tingling

Head Injury  
Fatigue  
Parkinsonism  
Trigeminal neuralgia  
Numbness

Dizziness  
Tremors  
Gait problems  
Loss of vision  
Easy bruising

Vertigo  
Shaking  
Balance problems  
Double vision  
Excessive bleeding

Memory loss  
Weakness  
Passing out  
Blurry vision  
Frequent infections

Blood in the urine  
Rash  
Fatigue  
Hair loss  
Tinnitus

Bladder incontinence  
Dry skin  
Heat sensitivity  
Hearing loss

Sexual difficulties  
Sensitive skin  
Cold sensitivity  
Ring in the ears

Snoring  
Chest pain  
Nausea  
Abdominal pain  
Blood and the stool

Difficulty swallowing  
Swelling in the ankles or legs  
Vomiting  
Diarrhea

Daytime sleepiness  
Heart palpitations  
Bowel incontinence  
Constipation

Joint swelling  
Muscle cramps  
Neck pain  
Loss of interest  
Hallucinations

Joint pain  
Joint stiffness  
Depression  
Trouble staying asleep  
Frequent worried thoughts

Muscle pain  
Back pain  
Trouble falling asleep  
Anxiety

*THANK YOU FOR TAKING YOUR TIME TO COMPLETE THIS FORM!*

Patient's Signature \_\_\_\_\_

Date \_\_\_/\_\_\_/2011