

## FILL OUT COMPLETELY – PLEASE PRINT

Name \_\_\_\_\_ Birth Date \_\_\_\_\_ SS# \_\_\_\_\_

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

Marital Status: S M W D Sep #Children \_\_\_\_\_ Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_

Employer \_\_\_\_\_ Occupation \_\_\_\_\_ Email Address \_\_\_\_\_

Spouse's Name \_\_\_\_\_ Occupation \_\_\_\_\_ Ladies, are you pregnant? \_\_Yes \_\_No

How did you hear about us? \_\_Phone book \_\_Ad \_\_Sign \_\_Referral-Name \_\_\_\_\_

Chiropractic before? \_\_Y \_\_N If yes, when? \_\_\_\_\_ Doctor's Name \_\_\_\_\_

Briefly describe complaints \_\_\_\_\_

Other Doctors seen for Complaints \_\_\_\_\_ When \_\_\_\_\_

Are complaints caused by an Auto Accident? \_\_Yes \_\_No (If yes, ask for injury form to fill out.)

Are complaints caused by a Work Injury? \_\_Yes \_\_No (Must have Employers Authorization before ANY Treatment)

List ALL surgeries and dates \_\_\_\_\_

List ALL drugs you are taking \_\_\_\_\_

List ALL vitamins you are taking \_\_\_\_\_

Have you EVER been diagnosed as having or suffering from:

Broken or Fractured Bones

Rheumatoid Arthritis

Seizures/Convulsions

A Congenital Disease

Excessive Bleeding

High/Low Blood Pressure

Circulation Problems

Epilepsy

Osteoarthritis

Pace Maker

Strokes

Cancer

Ulcers

Ruptures

Coughing Blood

Eating Disorder

Alcoholism

Drug Addiction

HIV Positive

Gall Bladder

Head Problems

Depression

Tumors

Other \_\_\_\_\_

**Payment Arrangements:** ( Check One) \_\_Cash/Check \_\_Credit Card \_\_Insurance (Must be verified in advance)

### READ CAREFULLY – IF YOU UNDERSTAND AND AGREE, SIGN BELOW

**Authorization & Assignment:** I hereby authorize and assign any and all insurance and/or third party benefits directly to Dr. Alan Schwartz and this office. I authorize the release of any and all information he deems necessary to anyone in order to process a claim for insurance or third party benefits on my behalf, and hereby release him of any consequences thereof.

I hereby authorize the doctor to treat my condition as he deems appropriate through the use of spinal adjustments (manipulation) and therapy throughout my spine/body. I understand and agree the amount paid the doctor for x-rays, is for examination and analysis of the x-rays only and the x-ray negatives will remain the property of this office. The doctor will not be held responsible for any pre-existing medically diagnosed conditions or medical diagnosis. I agree that I am responsible for any and all charges at this office whether paid by insurance or not.

I give Dr. Alan Schwartz consent to treat me / my minor children. All information is true to the best of my knowledge.

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

(Patient - Guardian)