

Chiropractic First, Family Wellness Center
Confidential New Member Information

Name: _____ Home Phone: _____ Work/Cell: _____ Date: _____
Address: _____ City/State/ZIP: _____
D.O.B.: _____ Age: _____ Who may we thank for referring you? _____
Is this for the whole family? Family: _____ Self: _____ Medicare? Yes No Car Accident? Yes No
Primary reason for consulting our office: _____
Occupation: _____ Employer: _____
Sex: M / F Single / Married / Divorced / Widowed Spouse's Name: _____
Name and Ages of Children: _____
Email: _____ Social Security Number: _____
Your hobbies/interests/activities: _____
Do you exercise? NO YES: How often? _____ What type? _____
Rate your diet: Healthy Average Poor Do you use Vitamins/Supplements: YES NO _____
Alcohol: Never/Rare/Moderate/Daily Smoker? No Yes ___ # packs/day since year: ___ Past smoker? No Yes

What is the present reason for consulting our office?

Symptom Relief Maintaining Your Current Level of Health Optimum Wellness

Previous chiropractic care? YES NO If yes, Dr.'s Name: _____ Last visit? _____

Other doctors you are currently seeing: _____

Current medications: _____

Over the counter drugs taken in the past 3 months: _____

List all surgeries: _____

List all accidents and falls: _____

Health is the most valuable asset in the world – YOU and YOUR FAMILY’S. Healing includes taking responsibility for that health. Aspects of this responsibility are attending the classes, following your care plan, and meeting your financial obligations. The insurance industry pays for the treatment of symptoms and disease. We do not treat symptoms and disease. We offer true healing through Chiropractic Care. Therefore we operate on a fee for service basis. However, you may submit your claims for your own personal reimbursement. Chiropractic care is not a treatment nor cure of disease. Chiropractic care is for the restoration and maintenance of full function and communication within the body, from the brain to every cell in the body, so that you may express your full potential for life and healing. Claims will be submitted for Medicare patients only for care that is deemed medically necessary. When the care is considered maintenance, we will no longer submit claims to Medicare, as this is a non-covered service.

I clearly understand that all services rendered to me are charged directly to me and that I am personally responsible for payment.

I hereby request and consent to the performance of chiropractic adjustments, other chiropractic procedures and if necessary diagnostic x-rays on me by the doctor of chiropractic named below and/or anyone authorized by the same doctor. I further understand and am informed that, as in all health care, there are some slight risks to treatment and do not expect the doctor to be able to anticipate or explain all risks and combinations; and wish to rely on the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known, is in my best interest. I have read this consent and intend this consent form to cover the entire course of my care and any care in the future.

Signature: _____

Witness: _____

Print: _____

Date: _____