

CONFIDENTIAL PRACTICE MEMBER INFORMATION

Welcome. This information is important, please print. Date _____

Name _____ SSN _____ Home Phone _____

Work Phone _____ Address _____

City _____ State _____ Zip _____

Birth Date _____ Age _____ Sex: M F Marital Status S M W D

Occupation _____ Employer _____ Address _____

City _____ State _____ Zip _____

Children _____

Who referred you to our office? _____

Have you ever been to a chiropractor before? _____ If so, when? _____

Do you have any symptoms? If so, what are they and how have they affected your life?

Are you currently under any Doctors care? _____

If this is work related have you reported it to your employer? Yes No

Is this related to an auto accident? Yes No Date of Accident _____

Females: Are you pregnant? Yes ___ No ___ Not sure _____

If the Doctor determines that services are necessary, all charges are payable when rendered.

What form of payment will you use? Cash _____ Check _____ MC/Visa _____

If you have insurance that covers chiropractic care, we can assist you in filing your claims.

Insurance Company Phone Number _____

Company _____ Policy Number _____ Claim/Group Number _____

OVER PLEASE ⇒

I understand and agree that health and accident insurance policies are an agreement between the carrier and myself. I clearly understand and agree that all services rendered me are charged directly to me and I am personally responsible for payment. I also understand if I suspend or terminate my care at this office, any outstanding charges for professional services rendered me will be immediately due and payable. I hereby authorize the doctor's at Powers Family Chiropractic and whomever they may designate as their assistants to administer any care as they deem necessary. I certify that the above information is true and correct.

Print Name _____ Signature _____

Terms of Acceptance

When an individual seeks chiropractic health care and we accept this individual for such care, it is essential for both to be working towards the same objective.

Chiropractic has only one goal. The goal is to eliminate subluxations within the spinal column, which interfere with the expression of the body's innate wisdom. It is important that you as the patient understand both the objective and the method that will be used to attain our goal. This will prevent any confusion or disappointment.

Adjustment: An adjustment is the specific application of forces to facilitate the body's correction of vertebral subluxation. Our chiropractic method of correction is specific adjustments of the spine.

Health: A state of optimal physical, mental, and social well being, not merely the absence of disease or infirmity.

Vertebral Subluxation: A misalignment of one or more of the 24 vertebrae in the spinal column which causes alteration of nerve function and interference to the transmission of mental impulses, resulting in a lessening of the body's innate ability to express its maximum health potential.

We do not offer to diagnose or treat any disease or condition other than vertebral subluxation. However, if during the course of chiropractic spinal examination we encounter non-chiropractic or unusual findings, we will advise you. If you desire advice, diagnosis, treatment for those findings, we will recommend that you seek the services of health care provider who specializes in that area.

Regardless of what the disease is called, we do not offer to treat it. Nor do we offer advice regarding treatment prescribed by others. **OUR ONLY PRACTICE OBJECTIVE** is to eliminate major interference to the expression of the body's innate wisdom. Our method is specific adjusting to correct vertebral subluxations.

I, _____ have read and fully understand the above statements.
(Print Name)

Signature _____