

# CONFIDENTIAL PATIENT HEALTH RECORD

Name: \_\_\_\_\_ Address: \_\_\_\_\_

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

Home Phone: \_\_\_\_\_ (emergency/appointment related only): Cell Phone: \_\_\_\_\_

Sex: \_\_\_ M \_\_\_ F Birth Date: \_\_\_\_\_ Age: \_\_\_\_\_ Marital: M S W D

Occupation: \_\_\_\_\_ Employer: \_\_\_\_\_ Work Phone: \_\_\_\_\_

**INSURED:** if different than above.

Name: \_\_\_\_\_ Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ Social Security#: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Sex: \_\_\_ M \_\_\_ F Birth Date: \_\_\_\_\_ Age: \_\_\_\_\_ Marital: M S W D

Occupation: \_\_\_\_\_ Employer: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Name and Number of Emergency Contact: \_\_\_\_\_ Relationship: \_\_\_\_\_

Referred to This Office By: \_\_\_ Sign \_\_\_ Yellow Pages \_\_\_ Ad \_\_\_ Insurance Co. \_\_\_ Website

\_\_\_ Friend - Name: \_\_\_\_\_

Purpose of This Appointment: \_\_\_\_\_ When did this condition Begin? \_\_\_\_\_

Other Doctors Seen for This Condition: \_\_\_ Yes \_\_\_ No Who? \_\_\_\_\_

Have You Ever Suffered From: \_\_\_ Rheumatic Fever \_\_\_ Stroke \_\_\_ Dizziness \_\_\_ Backaches \_\_\_ Heart trouble  
\_\_\_ Cancer \_\_\_ Tuberculosis \_\_\_ Diabetes \_\_\_ Arthritis \_\_\_ Headaches \_\_\_ Numbness \_\_\_ Asthma

Medications you now take: \_\_\_ Pain Killers/Muscle Relaxers \_\_\_ Blood Pressure \_\_\_ Insulin \_\_\_ Other

Name of Medications: \_\_\_\_\_

Do You Wear a Shoe Lift \_\_\_ Yes \_\_\_ No Female: Is There Any Chance You Are Pregnant? \_\_\_ Yes \_\_\_ No

Have You Been Treated For Any Health Conditions in the Last Year? \_\_\_ Yes \_\_\_ No Describe: \_\_\_\_\_

Major surgery/operations/Hospitalizations: \_\_\_\_\_

Major accidents, falls, and serious illness: \_\_\_\_\_

Previous Chiropractic Care: \_\_\_ Yes \_\_\_ No Name and date last seen: \_\_\_\_\_

Name of Medical Doctor: \_\_\_\_\_

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that Chudy Chiropractic Clinic 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 Chudy Chiropractic Clinic 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 fees for professional services rendered me will be immediately due and payable. All copay, coinsurance, or deductible balances are due at the time of service or per payment arrangement.

I hereby instruct and direct the \_\_\_\_\_ Insurance Company to pay by check made out and mailed directly to Chudy Chiropractic Clinic 2304 N. Grandview Blvd. Waukesha, WI 53188. If my current policy prohibits direct payment to doctor, then I hereby also instruct and direct you to make out the check to me and mail it to: C/O Chudy Chiropractic Clinic for professional or medical expense benefits allowable, and payable to me under my current insurance policy as payment toward the total charges for professional services rendered. **THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY.** This payment will not exceed my indebtedness to the above-mentioned assignee, and I have agreed to pay, in a current manner, any balance of said professional service charges for non-covered services and/or fees over and above this insurance payment, or as required by my insurance policy. **A PHOTOCOPY OF THIS ASSIGNMENT SHALL BE CONSIDERED AS EFFECTIVE AND AS VALID AS THE ORIGINAL.** I also authorize the release of any information pertinent to my case to any insurance company, adjuster, or attorney involved in this case.

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

Guardian/Spouse: \_\_\_\_\_ Date: \_\_\_\_\_

Witness: \_\_\_\_\_ Date: \_\_\_\_\_