CONFIDENTIAL PATIENT HEALTH RECORD

Name: ______________________________Address: ____

City: ___________________________________ State: _________ Zip Code: ________________

Cell Phone: ______________________________ Email (used for billing): __________________________________

Sex: ___ M ___ F Birth Date: ______________ Age: ______ Marital: M S W D

Occupation: _____________________ Employer: ________________________

INSURED: if different than above.

Name: ______________________________Address: ____

City: __________________________ State: ______ Zip Code: ____________

Cell Phone: ___________________ Sex: ___ M ___ F Birth Date: ______________ Age: ______ Marital: M S W D

Occupation: _____________________ Employer: _______________________

Name and Number of Emergency Contact: __________________________________ Relationship: ________________

Referred to This Office By: ___ Sign ___ Facebook or Social Media ___Internet Search ___ 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 Team Chudy LLC 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 Team Chudy LLC at N8W22520 Johnson Drive STE D, Waukesha, WI 53186. 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 Team Chudy LLC 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: ___________________