

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 ___ Antidepressants

Do you smoke ___ Yes ___ No Take birth control ___ Yes ___ No Been diagnosed with osteoporosis ___ Yes ___ No

Diagnosed with any types of cancer ___ Yes ___ No Depression ___ Yes ___ No Do you self-manipulate your neck ___ Yes ___ No

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: _____

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 Team Chudy LLC 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: _____