

Confidential Patient Information

Name _____ Phone: H _____ C _____

Address _____ City _____ ST _____ ZIP _____

Age _____ Date of Birth _____ Marital Status (Circle One) M S D W

Spouse's Name _____ # of Children _____

Email Address _____ Social Security Number ____-____-____

Occupation _____ Employer _____

Work Address _____ City _____ ST _____ Zip _____

Who may we thank for referring you to our office? _____

Have you ever had Chiropractic care before? (Circle one) Yes No Date _____

Is this injury or illness related to an auto accident? Yes No (If yes, please continue.)

Date _____ Location _____ Policy # _____

Your Auto Insurance Co. _____ Phone _____

Third Party Auto Insurance Co. _____ Phone _____

Due to changes in health insurance fees, patient courtesy billing has become a much more cost effective way for you, the patient to get reimbursement for your care. Self-billing allows us to keep our fees low so you can get the care you need without any added cost. Therefore, our policy is that all payment is due at the time of service and bills will be electronically submitted to your insurance provider. All payments from your insurance provider will be mailed directly to you. Statements after submission will be provided upon request.

Do you have any health insurance you would like us to check the benefits on? Yes No

All charges are due when services are rendered...

Method of payment: Check Cash Credit Card

Why Chiropractic? People go to Chiropractors for a variety of reasons. Some go for Symptomatic relief of pain or discomfort (Relief Care). Others are interested in having the cause of a problem as well as the symptoms corrected and relieved (Corrective Care). Your Doctor will weigh your needs and desires when recommending your treatment program. **Please Circle the type of care that best meets your needs.**

Relief Care

Relief care is that care necessary to get rid of your symptoms or pain, but not the cause of it. It is the same as drying a floor that was getting wet from a leak, but not fixing the leak.

Corrective Care

Corrective Care differs from relief care in that the goal is to get rid of the symptoms or pain while correcting the cause of the problem. Corrective care varies in length of time but is more lasting.

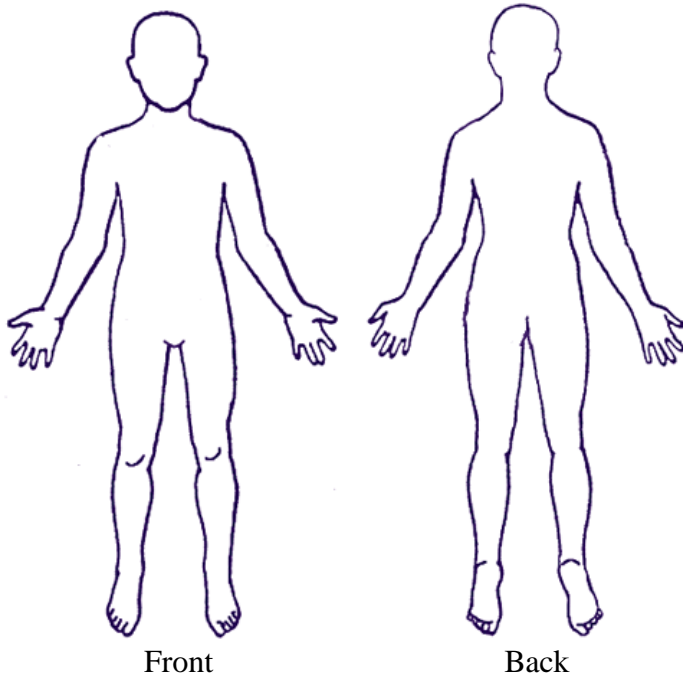
I authorize Potocki Family Chiropractic and Laser center Inc to render services to me and I am responsible for all charges incurred.

Patient Signature _____ Date _____

Guardian or Spouse's authorizing care _____

THANK YOU FOR ALLOWING US TO SERVE YOU!

PLEASE MARK AN X IN THE
DIAGRAM BELOW WHERE YOUR
PROBLEMS ARE



Name _____ Date _____

What hurts and how long has it hurt?

1. _____
2. _____
3. _____
4. _____

List your chief complaints in order of severity.

1. _____
2. _____
3. _____
4. _____

List other Chiropractic or Medical Doctors you
have consulted for these conditions.

1. _____
2. _____
3. _____
4. _____

Check any of the following you have had in the last six months:

- | | |
|--|--|
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Numbness |
| <input type="checkbox"/> Sinus congestion / allergies | <input type="checkbox"/> Frequent nausea / vomiting |
| <input type="checkbox"/> Vision Problems | <input type="checkbox"/> Abdominal cramps |
| <input type="checkbox"/> Earaches | <input type="checkbox"/> Constipation |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Diarrhea |
| <input type="checkbox"/> Heart problems | <input type="checkbox"/> Poor / excessive appetite |
| <input type="checkbox"/> Lung problems / congestion | <input type="checkbox"/> excessive thirst |
| <input type="checkbox"/> Blood pressure problems | <input type="checkbox"/> Painful / excessive urination |
| <input type="checkbox"/> Ankle swelling | <input type="checkbox"/> Discolored urine |
| <input type="checkbox"/> Prostate / sexual dysfunction | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Menstrual cycle dysfunction | <input type="checkbox"/> Cancer |

Are you pregnant? Yes No Not sure