

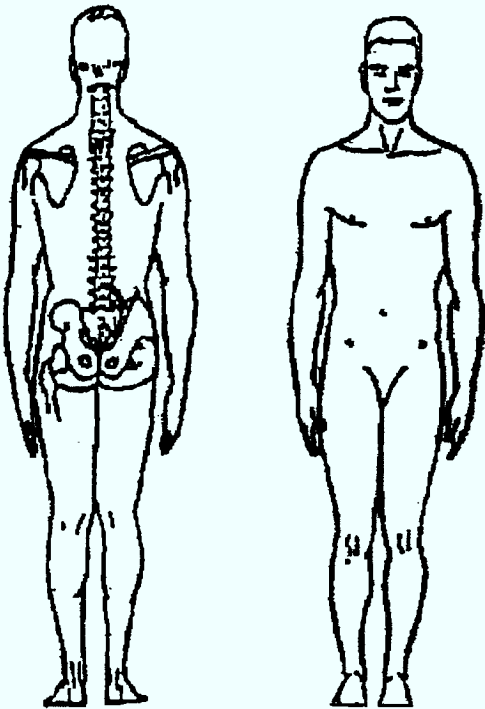
INFORMATION/APPLICATION FOR CARE

The following information is needed in order to better serve you. Please complete all questions. If you need help please ask the receptionist. PLEASE PRINT.

Name _____ Today's Date _____
Home Phone _____ Work Phone _____ Cell Phone _____
E-Mail Address _____
Address _____ City _____ State _____ Zip _____
Age _____ Birth date _____ Marital Status: S M W D Number of Children _____

Please circle one payment type: Cash Check Master Card/Visa

Your Employer _____ Occupation _____ Years On Job _____
Employer Address _____ City _____ State _____ Zip _____
Your Social Security # _____ Do you have Medicare? Yes _____ No _____
Name of Spouse or Parent _____ Their Birth date _____
Spouse Employed By _____ Occupation _____ Years On Job _____
Employer Address _____ City _____ State _____ Zip _____
Office Phone # _____ Spouse's SS# _____
Driver's License # _____



COMPLETE THESE DIAGRAMS

If you are in pain, please mark the exact location of your pain on the diagram. Also describe the type and frequency of your pain, as well as any activity which brings on or aggravates the pain. For example; dull, sharp, consistent, off & on, when standing, when sitting, etc.

MAJOR COMPLAINTS

(Please list any condition you are being treated for or are experiencing.)

Referred to our office by: _____

How payment will be made:

_____ Cash _____ Check _____ Credit Card
_____ Automobile Insurance Policy _____ Workman's Compensation

Is your condition due to an accident? Yes _____ No _____ Date of accident? _____
Type of accident? Auto _____ Work/On Job _____ At Home _____ Other _____
Have you ever been in an auto accident? Past Year _____ Past 5 Years _____ Over 5 Years _____ Never _____

(OVER)

INFORMATION/APPLICATION FOR CARE

I (we) agree to pay for services rendered for the above mentioned patient as the charge is incurred. I understand and agree that health & accident insurance policies are an arrangement between an insurance carrier and myself and that I am personally responsible for payment of any and all services covered not covered. I also understand that if I suspend or terminate my care and treatment, any fee for professional services rendered to me will be immediately due and payable. Should my account be referred for outside collection, I agree to pay all collection costs, attorney fees and court costs. A 1.25% monthly (15% APR) may be assessed on the unpaid balance of any and all of my accounts.

Patient's Signature _____ Date _____

Or Guardian Signature _____ Date _____

Notice to our new patients: Full payment for services rendered is due at the end of each visit. If for any reason this request cannot be met, arrangements should be made in advance before seeing the doctor.