For office use only

Acct # _____ Date: _____

PERSONAL HISTORY

Name:_____ **Sex (circle one):** M F

Address:_____ **City:**_____ **State:**_____ **Zip:**_____

Home Phone:_____ **Work:** _____ **Cell:**_____

Race:☐Decline to State ☐Black/African American ☐White ☐Hispanic ☐Asian **Ethnicity:** ☐Decline to State ☐Hispanic/Latino ☐Not Hispanic/Latino

Birthdate:_____ **Age:**_____ **Height:**_____ **Weight:**_____

Marital Status:_____ **S. S. #:**_____

☐ **Yes,** I would like to be reminded of appointments by the following method: ☐Voice Message to Home ☐ Voice Message to Cell ☐Text

Employer Name:_____ **Occupation:** _____

Employer Address:_____

Family Physician:_____

Do you smoke: [ ] Never Have [ ] Quit [ ] Yes _____pk/day _____years

Alcohol consumption: [ ] Never [ ] Social [ ] Light [ ] Moderate [ ] Heavy

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CURRENT HEALTH CONDITION

Symptoms:_____

Is it due to: [ ] Auto Accident [ ] Slip & Fall [ ] Other Accident _____

Date of Accident or Injury: _____ Were you on the job when it occurred?_____

Are the symptoms: [ ] Improving [ ] Getting Worse [ ] About the same [ ] Intermittent (come and go)

Dates symptoms appeared:_____ Have you had these symptoms before? [ ] Yes [ ] No

If yes when_____

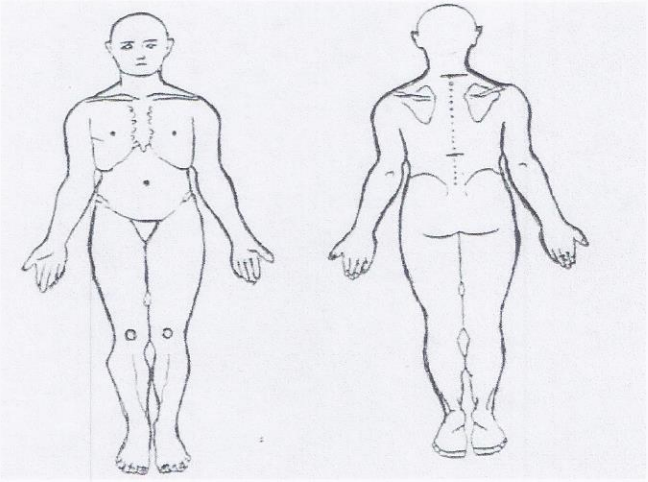
Aggravated by: [] Standing [] Walking [] Sitting [] Lying [] Bending [] Lifting [] Twisting [] Coughing

Medication now taken: [] Nerve pills [] Painkillers [] Muscle relaxers [] Blood pressure [] Insulin [] Asprin

[] Other: _____

Current health problems in addition to symptoms list above:_____

Please outline on diagram your area of pain or discomfort as completely as possible.



(Females Only) When was your last period?_____ Do you get PMS? [] Yes [] No

Are you pregnant at this time? [] Yes [] No [] Not sure

PAST MEDICAL HISTORY

Major Surgeries: [] Appendix (year?)_____ [] Tonsils_____ []Gall Bladder_____ [] Hernia_____

[]Heart_____ [] Back_____ [] Neck_____ [] Leg_____ [] Female_____

[] Other (Type & Year)_____

Fractures (Type & Year):_____

Serious Illnesses (Type & Year):_____

Emergency Contact (not living with you): _____

Relationship:_____ Number 1:_____ Number 2:_____

Address:_____

I hereby direct payment to be made directly to Barczyk Chiropractic Group and assign Barczyk Chiropractic Group a lien in the amount of my bill for health care services against any proceeds of any insurance policy, health care plan, and against any claim which I may have against any other party whose negligence may have caused my injuries, or who may legally be responsible for my injuries, illness or health care cost. I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that the Doctor's Office will prepay any necessary reports and forms to assist me in making collection from the insurance and that any amount authorized to be paid directly to the Doctor's Office 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**. Further, I understand that if my account becomes 60 days overdue with no acceptable payment, my account will be turned over to a collection agency/attorney, and I will be responsible for all fees involved in addition to my original balance. I also understand that if I suspend or terminate my care at this office, any outstanding charges or professional services rendered me will be immediately due and payable. I further certify that the above information is true and correct to the best of my knowledge and will notify you with in 2 weeks of any changes in the information contained herein. I understand the insurance verification done by this office and discussed with me as provided by my insurance representative is not a promise or guarantee of payment by my insurance carrier and I will not hold this clinic responsible for discrepancies in the benefit quoted and the benefit actually paid.

Parent/Guardian
Signature:_____ Date:_____

I acknowledge that I have received a copy of this clinic's Privacy Notice:_____