Sigafoose & Jackson Family Chiropractic Date_____

Last Name _____ First Name _____ M.I. _____
Address _____ City/State _____ Zip _____
Home Phone _____ Work Phone _____ S.S. # _____
Age _____ Birthdates _____ Sex _____ Marital Status _____
Number of Children _____ Name/Ages _____
Occupation _____ Employer _____
Referred by _____ Have you seen a chiropractor before? _____ When? _____
Medications _____
Surgeries _____
Auto Accidents _____ Serious Falls/Injuries _____

Is your condition due to a work injury? Yes No (If yes, please fill out #3 below)
Is your condition due to an auto accident? Yes No (If yes, please fill out #2 below)
Is there any chance that you are pregnant? Yes No

Health History

What is your major complaint? _____
How long have you had this condition? _____
Other doctors who have treated you for this condition? _____

Please check box below that apply and complete requested information

1. ***Insurance Information*** – Please give card to the receptionist to copy and sign #1, #2 and #3 on the back of this form.

Relation to Insured: Self Spouse Dependent Other
If other than self: **Name:**_____
DOB: _____

2. ***Personal Injury/Auto Accident*** **–** Please ask receptionist for a personal injury form.
Claim # _____ **Date of injury** _____
Relation to insured: Self Spouse Dependent Other

3. ***Workers' Compensation*** **–** Please ask receptionist for a job injury form
Claim # _____ **Date of injury** _____
4. ***No Insurance***

Please check all that apply

_____ Neck _____Headache _____Arms _____Hands

_____ Upper Back _____Shoulder (R/L) _____Chest _____Abdomen

_____Mid Back _____Low Back _____Hips _____Legs

_____Knees _____Feet

____Anxiety ____Swelling ____Fainting ____Neuritis

____Nausea/Vomiting ____Tension ____Pain behind eyes ____Fatigue

____Tremors ____Sinus Trouble ____Depression ____Restricted/ Motion

____Excessive Perspiration

1. Assignment

I hereby instruct and direct my insurance company to pay by check made out and mailed directly to this clinic the professional or medical expense benefits allowable, and otherwise payable to me under my current insurance policy as payment toward the total charges for professional services rendered by this clinic. A photocopy of this assignment shall be considered as effective and valid as the original.

_____ _____

Patient Signature Date

2. Release of Information

I authorize this clinic to release any information pertinent to my case to any insurance company, adjustor, and/or attorney involved in this case, and hereby release this clinic of any consequence thereof.

_____ _____

Patient Signature Date

3. Financial Responsibility

I agree to be financially responsible for all charges incurred at this clinic including my insurance deductible, co-payment, and any services rejected by my insurance company.

_____ _____

Patient Signature Date

_____ _____

Parent or Guardian Signature Authorizing Care Date