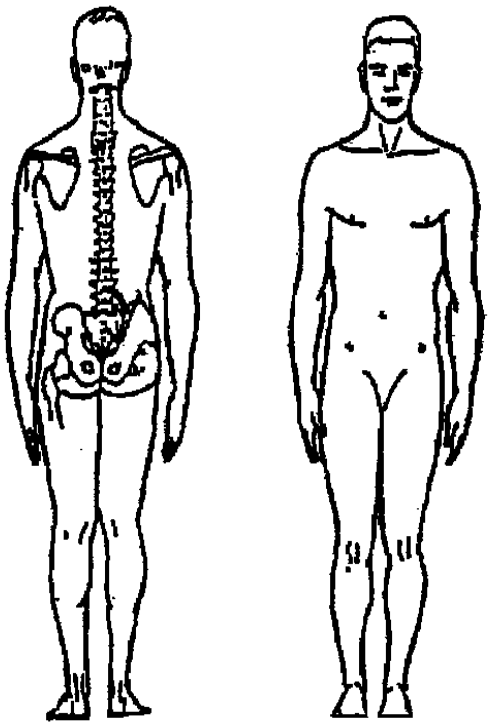
INFORMATION/APPLICATION FOR CARE

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.

Today's Date: ___/___/_____

Name _____ Home Phone _____ Work Phone _____
Cell Phone _____-_____-_____ Email Address: _____
Address _____ City _____ State _____ Zip _____
Age _____ Birthdate ____/_____/_____ 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 _____
Insurance Company _____Your SSN # ____-_____ -_____
Do you have Medicare? Yes ____ No ____
Name of Spouse or Parent _____ Their Birthdate _____
Spouse Employed By _____ Occupation _____Years On Job ____
Employer Address _____ City _____ State _____ Zip _____
Office Phone # _____ Spouse's SSN# _____
Does your spouse have health insurance at work? Yes _____ No _____



COMPLETE THESE DIAGRAMS

If you are in pain, please mark the exact location of your pain on the diagram. Also, circle or describe the type and frequency of your of your pain, as well as any activity which brings on or aggravates the pain.

MAJOR COMPLAINTS

Conditions you are experiencing: _____
_____
_____
Date Condition Started: ____/_____/_____
What Caused Condition: _____
_____
Describe Pain: Dull, Sharp, Burning, Gnawing,
Other_____
Describe Frequency: Constant, Intermittent, On Activity, Daily,
Other: _____
What Makes it Worse: Sitting, Standing, Bending, Walking,
Working, Reading, Driving, Computer, Phone, Activities,
Other: _____
_____
_____

Referred to our office by: _____
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 ____

Type of payment: ___ Self Pay ___ Worker's Comp ___Health Insurance ___Automobile Insurance

I (we) agree to pay for services rendered to 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 or not covered. I also understand that if I suspend or terminate my care and treatment, any fee for professional services rendered me will be immediately due and payable.

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.

Insurance cases: On all insurance assignments, the deductible should be met in the beginning unless prior arrangements are made.

If any balances are 30 days past due I agree to allow New Hope Family Chiropractic clinic to charge the un-paid balance to my credit card. Signature: _____ Date _____
Master Card/Visa # _ _ _ _ - _ _ _ _ - _ _ _ _ - _ _ _ _ Security # _____
Expire Date: _____