

**INSTRUCTIONS:** Please Print

**TODAY'S DATE:** \_\_\_\_/\_\_\_\_/\_\_\_\_

**NAME:** \_\_\_\_\_ **SOCIAL SECURITY #** \_\_\_\_ - \_\_\_\_ - \_\_\_\_

**ADDRESS:** \_\_\_\_\_ **CITY/STATE/ZIP:** \_\_\_\_\_

**HOME PHONE:** (\_\_\_\_) \_\_\_\_\_ **WORK PHONE:** (\_\_\_\_) \_\_\_\_\_ **FAX #:** (\_\_\_\_) \_\_\_\_\_ **EMAIL:** \_\_\_\_\_

**BIRTH DATE:** \_\_\_\_/\_\_\_\_/\_\_\_\_ **AGE:** \_\_\_\_ **SEX:** M F **MARITAL STATUS:** S M D W **# OF CHILDREN** \_\_\_\_\_

**OCCUPATION:** \_\_\_\_\_ **EMPLOYED BY:** \_\_\_\_\_

**SPOUSE'S NAME:** \_\_\_\_\_ **EMPLOYED BY:** \_\_\_\_\_

**REFERRED BY:** Friend/Relative Newspaper Yellow Pages Sign Other \_\_\_\_\_

Which one of our patients may we thank for referring you? \_\_\_\_\_

I am seeking help for (please circle all that apply):

- |                       |                   |                         |                |                              |                   |
|-----------------------|-------------------|-------------------------|----------------|------------------------------|-------------------|
| 01) Sinus             | 08) Migraines     | 15) Upper Back Pain     | 22) Foot Pain  | 29) Low Back Pain            | 36) Weak Immunity |
| 02) Hip Pain          | 09) Jaw – TMJ     | 16) Neck Pain           | 23) Numbness   | 30) Mid Back Pain            | 37) Infertility   |
| 03) Chest Pain        | 10) Asthma        | 17) Neck Stiffness      | 24) Digestion  | 31) Hand/Wrist Pain          | 38) Depression    |
| 04) Allergies         | 11) Arthritis     | 18) Tailbone Pain       | 25) Headaches  | 32) Menstrual problems       |                   |
| 05) Arm Pain          | 12) Sciatica      | 19) General Health      | 26) Bedwetting | 33) Fibromyalgia             |                   |
| 06) Knee Pain         | 13) Ulcers        | 20) Nervousness/tension | 27) Leg Pain   | 34) Chronic Fatigue Syndrome |                   |
| 07) Chronic Infection | 14) Shoulder Pain | 21) Ankle Pain          | 28) Elbow Pain | 35) Other: _____             |                   |

**Other Complaints** (please specify): \_\_\_\_\_

My condition is due to (please circle):

- |                      |                      |                 |
|----------------------|----------------------|-----------------|
| 01) Auto Accident    | 03) Sports Accident  | 05) Unknown     |
| 02) Accident at Work | 04) Accident at Home | 06) Other _____ |

I Desire (please circle): 1) Maximum Improvement 2) Temporary Relief

Have you ever had spinal surgery? (No) (Yes) Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

**Females Only:** Are you pregnant at this time? (No) (Yes)

Previous Chiropractor: \_\_\_\_\_ Medical Doctor: \_\_\_\_\_

When was your last medical physical (approximate date)?: \_\_\_\_/\_\_\_\_/\_\_\_\_

How long has it been since your last Chiropractic adjustment? \_\_\_\_\_

I agree to pay for services rendered to the above-mentioned patient as the charge is incurred. I understand and agree that health and accident insurance policies are an arrangement between the insurance carrier and myself and that I am personally responsible for payment of any and all services covered or non-covered. I also understand that if I terminate my care and treatment, any fees for professional services rendered to me will be immediately due and payable.

I authorize the doctor and his staff to release any information deemed appropriate concerning my physical condition to any insurance company, attorney, or adjuster in order to process any claim for reimbursement of charges incurred by me as a result of professional services rendered. I hereby release him/her of any consequence thereof. I agree that a photocopy of this agreement shall serve as the original.

I hereby authorize and direct payment of any medical/chiropractic expense benefits allowable to the doctor as payment toward the total charges for professional services rendered. This payment will not exceed my indebtedness to the assignee. I agree that a photocopy of this agreement shall serve as the original.

I understand that payment is expected at the time of service. I choose to pay by (please check ✓):

- |                          |                               |                |
|--------------------------|-------------------------------|----------------|
| _____ Cash/Check         | _____ Worker's Comp Insurance | _____ HMO      |
| _____ Credit Card        | _____ Group Health Insurance  | _____ Medicare |
| _____ Spouse's Insurance | _____ Auto Insurance          | Other _____    |

Patient's Signature \_\_\_\_\_ Date \_\_\_\_/\_\_\_\_/\_\_\_\_

(If you are under 18 years of age, we need a parent or guardian signature authorizing us to treat you.)

Parent/Guardian Signature \_\_\_\_\_ Date \_\_\_\_/\_\_\_\_/\_\_\_\_

**POTISK CHIROPRACTIC OFFICE, S.C.** ♦ 1333 College Avenue ♦ South Milwaukee WI 53172 ♦ 414-762-8441