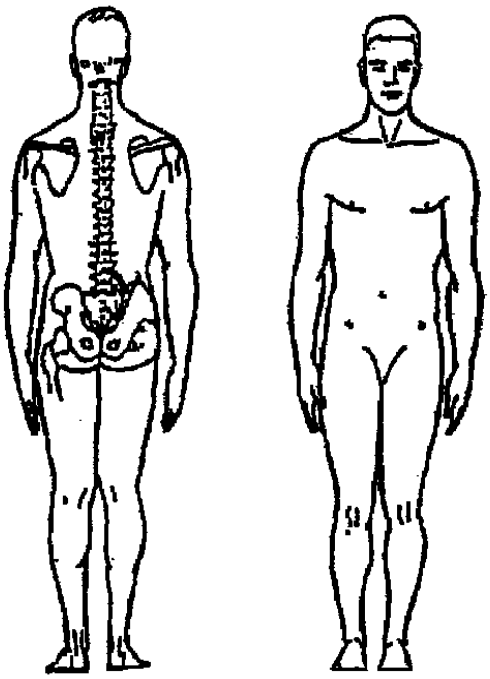
The following information is needed in order to better serve you. Please complete all questions. If you need help please ask the receptionist. **PLEASE PRINT**.

Name _____ Home Phone _____ Cell Phone _____
Address _____ City _____ State _____ Zip _____
Age _____ Birth date _____ Marital Status: S M W D Number of Children _____
Your Employer: _____ Occupation: _____ Years on job: _____
Emergency Contact Name: _____ Phone #: _____
Do you have insurance that covers chiropractic care? Yes/No Social Security #: _____



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.)

1. _____
2. _____
3. _____
4. _____
5. _____

How did you hear of our office? ☐ Website ☐ Phone book ☐ Referral
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 _____

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 me 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 fees for professional services rendered me will be immediately due and payable.

Please circle one payment type: Cash Check Master Card Visa

In consideration of allowing ***Active Life Chiropractic*** to render care, I agree to the following:

Release of Information

1. I hereby authorize **Active Life Chiropractic** to release any information they deem necessary and appropriate concerning my condition to any insurance company, attorney or adjuster in order to process any claim for reimbursement of charges incurred by me at **Active Life Chiropractic**. _____ (initial)

Right to Receive Payment

2. I hereby authorize and assign to **Active Life Chiropractic**, the medical provider the right to receive direct payment from my attorney or any insurance company who may become obligated to pay any sums. I further authorize the endorsement of my name to any draft or check containing my name to which **Active Life Chiropractic** is legally entitled. _____ (initial)

NOTE: WE DO NOT FILE CLAIMS FOR WORK COMP OR PI CASES. YOU WILL BE RESPONSIBLE FOR PAYMENT AND WE WILL GIVE YOU RECEIPTS THAT YOU CAN SUBMIT FOR REIMBURSEMENT. (_____) initial

Patient's Signature _____ Date _____
Or Guardian Signature _____ Date _____