WELCOME TO OUR OFFICE

Name_____ Male / Female Date _____

Address _____ City _____ State _____Zip_____

Age_____Birthdate_____/_____/_____ Social Security # _____

Home Phone #_____Cell Phone #_____

E-mail Address _____

☐ Married ☐ Widowed ☐ Single ☐ Minor

☐ Separated ☐ Divorced ☐ Partnered for _____ years

Employed: (circle one) F/T P/T Student Retired Employed By_____

Occupation_____ Work Phone_____

Spouse's Name_____Spouse's Employer_____

Insurance Company Name_____ Insured is: Self / Spouse / Parent

Medical Doctor_____ Last Visit_____/_____/_____

In case of emergency, please notify:_____

Relation to you:_____Phone #_____

WHOM MAY WE THANK FOR REFERRING YOU TO OUR OFFICE..... ***CIRCLE ONE BELOW:***

Yellow Pages Drive By Patient Referral From _____ Ins Co Website Internet Other

I hereby give permission to the doctor to release any information requested by my insurance company acquired in the course of my examination and treatment.

I hereby authorize and direct my insurance benefits to be paid directly to the doctor and to execute such insurance claim forms and other documents on my behalf as may be necessary to receive payment. I am financially responsible for non-covered services. I agree to pay attorney fees and costs if legal action is required to collect for services. I understand that there is a FIFTEEN ($15) DOLLAR late fee that will be assessed on ALL dates of service that are 30 or more days PAST DUE and that I will continue to incur a FIFTEEN ($15) DOLLAR late fee every 30 days until the balance is paid in full.

I acknowledge that my medical records will be retained for SEVEN (7) YEARS from date of service. Any medical records older than SEVEN (7) YEARS may be destroyed.

I hereby give permission to the doctor to administer treatment and perform such procudures as he may deem necessary in the diagnosis and/or treatment of my condition.

I HAVE READ AND AGREE TO THE ABOVE

SIGNATURE_____ DATE_____

(Patient, or Parent/Guardian if Minor)

PATIENT INFORMATION

Name:_____ Date:_____

Height: _____ **Weight:** _____**lbs** **Blood Pressure:** _____ /_____

Pacemaker: **YES** **NO**

Smoking Status:

☐ Current every day smoker.....Started smoking in year: _____

☐ Current some day smoker.....Started smoking in year: _____

☐ Former smoker.....Started smoking in year: _____ Stopped smoking in year: _____

☐ Never smoker

☐ Heavy tobacco smoker.....Started smoking in year: _____

☐ Light tobacco smoker.....Started smoking in year: _____

Do you have any *MEDICATION* allergies?

- ☐ No known medication allergies
- ☐ Yes. What? _____

Are you currently taking any medications?

- ☐ Not currently prescribed any medications
- ☐ Yes...

What? _____ _____ mg

What? _____ _____ mg

What? _____ _____ mg

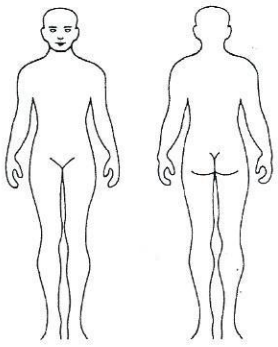
What? _____ _____ mg

What? _____ _____ mg

What? _____ _____ mg

What? _____ _____ mg

Please mark an "X" on what part of your body is bothering you.



FAMILY HEALTH HISTORY

Patient Name: _____ Date:_____

Please review the below listed diseases and conditions and indicate those that are current or past health problems of a family member with an "X" under the

	Mother	Father	Sister	Brother	Daughter	Son
Anemia						
Arthritis						
Atherosclerosis						
Cancer						
Cardiovascular disease						
Congenital Anomaly						
Crohn's disease						
Diabetes						
Gastrointestinal disease						
Gout						
Ischemic Heart Disease						
Hypercholesterolemia						
Hypertension						
Hyperthyroidism						
Hypothyroidism						
Leukemia						
Malignant Neoplasm of Lung						
Malignant Melanoma						
Migrane						
Multiple Sclerosis						
Neurological disorder						
Osteoporosis						
Polycystic Ovaries						
Prostate Cancer						
Rheumatiod Arthritis						
Stroke						
Thalassemia						
Thyroid Disorder						
Tuberculosis						

Have you had X-RAYS taken on ANY part of your body in the past 10 years?

If **YES**.....What part of your body?_____

WHERE were they taken?_____

_____

Signature of Patient

CHIROPRACTIC HEALTH CENTER

FEE SHEET

PLEASE READ THE FOLLOWING AND MARK THE APPROPRIATE BOX.

We are required to process certain paperwork for particular types of billing cases. Please inducate which type of patient you are so that we can be thorough in handling your case.

( ) I believe I am a **CASH** patient. Cash patients are responsible for all of their charges and must pay for them at the time of service unless other specific arrangements have been made.

( ) I believe I am an **INSURANCE** patient. Insurance patients are responsible for all their charges. This office may or may not choose to bill your insurance company and accept assignment for payment towards your account. We must have a copy of your insurance card. After your insurance coverage has been verified, you will need to pay your deductible, co-payments and any charges not paid by your insurance company.

( ) I believe I am a **MEDICARE** patient. We must have a copy of your insurance card. You will be responsible for your annual deductible if you do not have a secondary policy.

( ) I believe I am a **WORK INJURY** patient. If a valid claim is not established, the patient is responsible for all charges.

( ) I believe I am a **PERSONAL INJURY** patient. Personal injury patients have usually been in an auto accident or have had a slip and fall type injury where someone else is liable for their medical charges. Extensive paperwork and documentation is needed; sometime lawyers are involved. If a valid claim is not established, the patient is responsible for all charges.

I understand that there is a fifteen ($15) dollar late fee and/or 18% interest that will be assessed on all dates of service that are 30 or more days past due and that I will continue to incur a fifteen ($15) dollar late fee every 30 days until the balance is paid in full. I agree to pay attorney fees and costs if legal action is required to collect for services. I acknowledge that my medical records will be retained for seven (7) years from date of service. Any medical records older than seven (7) years may be destroyed.

I hereby give permission to the doctor to administer treatment and perform such procedures as he may deem necessary in the diagnosis and/or treatment of my condition.

Patient's Name _____ Date_____

Chiropractic Health Center
Dr. Alan S. Bader, D.C.
Dr. Micky R. Doyle, D.C.
294 East Moana Lane, Suite 28
Reno, NV 89502
Katrina Raschen, Privacy Officer
(775) 829-7575

Notice of Privacy Practices Receipt

I acknowledge that I was provided with the Notice of Privacy Practices of the Medical Practice named at the top of this page.

Print Name of Patient:_____

Date of Birth: _____

_____ _____
Signature of Patient Date

For Personal Representative of the Patient (if applicable)

Print Name of Personal Representative: _____

Relationship (parent, guardian, power of attorney, etc.): _____

I hereby certify that I have the legal authority under applicable law to make this request on behalf of the patient identified above.

_____ _____
Signature of Personal Representative Date