INFORMATION/APPLICATION FOR CARE

Bay Area Chiropractic 10785 Ulmerton Road Largo Florida 33778

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 _____ Cell Phone _____

Address _____ apt/lot # _____ City _____ State _____ Zip _____

Age _____ Date of Birth _____ SS # _____ Marital Status: S M W D # of Children _____

Dominant Hand? Right Left Both Email Address _____

Your Employer _____ Occupation _____ Years on Job _____

Employer's Address _____ City _____ State _____ Zip _____

Insurance Company _____ SS # of Primary Insured _____

Do you have Medicare? ( )Yes ( )No Your Work Phone _____

Name of Spouse/Significant Other _____ Date of Birth _____

Spouse Employed by _____ Occupation _____ Years on Job _____

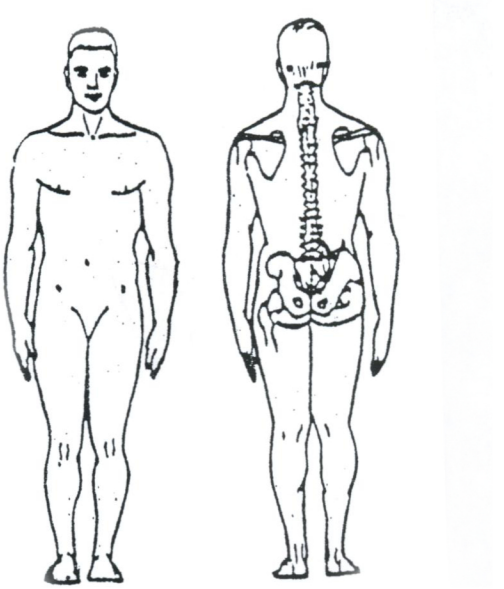
Employer Address _____ City _____ State _____ Zip _____

Work Phone _____ Spouse SS# _____ Driv Lic # _____

Does your spouse have 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, please describe the type and frequency of your pain, as well as any activity which brings on or aggravates the pain. For example: sharp, dull, consistent, off & on, when standing, when sitting, etc.



Major Complaints

(Please list any condition you are being treated for or are experiencing)

_____

_____

_____

_____

_____

Referred to our office by _____

Type of Insurance: ( )Health Insurance ( )Auto Insurance ( )Workmen's Comp

How Payment Will Be Made: ( )Cash ( )Check ( )Credit Card Is Your Condition Due to an Accident? ( )Yes ( )No

Type of Accident: ( )Auto ( )Work/On Job ( )At Home ( )Other _____ Date of Accident _____

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