Alix Chiro*Rehab*

6880 Perimeter Dr., Ste. A
Dublin, OH 43016
Phone: (614) 791-0077
Fax: (614) 791-0011

FULL NAME: _____

ADDRESS: _____

CITY, STATE, ZIP: _____

SS#_____ DOB: _____

PRIMARY PHONE #_____ SECONDARY PHONE #_____

EMAIL: _____

EMPLOYER: _____

ADDRESS: _____

PERSON TO CONTACT IN CASE OF EMERGENCY: _____

PHONE#_____

WHOM MAY WE THANK FOR REFERRING YOU TO US? _____

INSURANCE INFORMATION:

NAME OF INSURED: _____ DOB: _____

EMPLOYER: _____

(GIVE INSURANCE CARD AND PICTURE ID TO RECEPTIONIST)

AUTHORIZATION:

I hereby request and consent to the performance of all chiropractic/physical therapy treatment/procedures. I understand there are some risks to treatment including but not limited to, fractures, disc injuries, strokes, dislocations, and sprains. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely on the doctor to exercise judgment during the course of the procedure which the doctor feels at the time that's in my best interest. I certify I have read the above and answered all questions to the best of my knowledge. I authorize the release of any records to be given to third party payers, and that payments are to be made to the chiropractor. I know I am financially responsible for all charges rendered. If my account becomes delinquent and must be sent to a third party collection agency, there will be a charge of forty percent of the account balance.

SIGNATURE: _____ DATE: _____

NAME: _____ DATE: _____

HEIGHT: _____ WEIGHT: _____

CHIEF COMPLAINT: _____

PRIMARY CARE PHYSICIAN: _____ PHONE# _____

HAVE YOU CONSULTED OTHER DOCTORS FOR THIS PROBLEM? IF YES, THEN WHO?

_____

IS YOUR CONDITION RELATED TO A WORK RELATED INJURY/AUTO ACCIDENT/ HOME OR OTHER ACCIDENT? _____

IF SO, PLEASE DESCRIBE: _____

_____

WHEN DID SYMPTOMS BEGIN? _____

HAVE YOU HAD THIS PROBLEM BEFORE? _____

LIST CURRENT MEDICATIONS: _____

_____

LIST ALL MEDICAL PROBLEMS: _____

_____

DO YOU HAVE A PACEMAKER? _____

FAMILY MEDICAL HISTORY: _____

LIST ALL MAJOR SURGERIES, HOSPITALIZATION DATES, AND DOCTORS: _____

_____

<u>FOR FEMALES ONLY:</u>

ARE YOU PREGNANT? _____ LMP: _____

NOTICE OF PRIVACY ACT: I acknowledge and understand I have certain rights to privacy under the Health Insurance Portability & Accountability Act of 1996 (HIPPA). I acknowledge I received your Notice of Privacy Practices.

Patient name: _____

Relationship to patient: _____

Signature: _____

Date: _____