APPLICATION FOR TREATMENT

NAME_____TODAY'S DATE_____
DATE OF BIRTH_____ CONTACT PHONE NUMBER_____
ADDRESS_____CITY_____STATE____ZIP CODE_____
YOUR OCCUPATION_____REFERRED BY_____
EMAIL_____
CHECK ONE: □ MARRIED □SINGLE □ WIDOWED □ DIVORCED □SEPARATED
NAME OF SPOUSE_____ AGES OF CHILDREN_____
WHO'S RESPONSIBLE FOR BILL? □ SELF □ SPOUSE □ EMPLOYER
□ INSURANCE □ OTHER _____
IS INSURANCE THROUGH AN EMPLOYER?_____
HOW PAYMENT WILL BE MADE: □ CASH □ CHECK □ CREDIT CARD
□ WORKMEN'S COMP □ HEALTH INSURANCE □AUTO INSURANCE POLICY
INSURANCE COMPANY AND ADDRESS_____
POLICY NUMBER_____
YOUR REASON FOR TODAY'S
CONSULTATION_____

HOW DID THIS CONDITION DEVELOP? WHAT CAUSED IT? HOW DID IT START? _____

WHEN WAS THE MOST RECENT TIME YOU WERE AWARE OF THIS PROBLEM?

HAVE YOU EVER HAD THIS PROBLEM OR SIMILAR PROBLEM BEFORE? IF YES, EXPLAIN

HAVE YOU EVER RECEIVED TREATMENT FOR THIS CONDITION? WHERE AND WHEN, AND WHAT WERE YOUR RESULTS? _____

HAS THIS PROBLEM BEEN GETTING BETTER, WORSE, OR STAYING THE SAME? _____
IS THERE ANYTHING YOU DO THAT MAKES YOUR CONDITION WORSE? ____

IS THERE ANYTHING YOU DO THAT MAKES YOUR CONDITION BETTER?

HOW HAS THE CONDITION AFFECTED YOUR ACTIVITIES OF DAILY LIVING?
A. HOME LIFE_____
B. OCCUPATIONAL LIFE_____
C. REST AND SLEEP_____

SEE REVERSE SIDE

HAVE YOU EVER BEEN IN AN AUTOMOBILE ACCIDENT? □ PAST YEAR
□ PAST 5 YEARS □ OVER 5 YEARS □ NEVER
ANY TWISTED ANKLES, FALLS, OR ACCIDENTS IN YOUR PAST ETC.?

_____

ANY MEDICAL DIAGNOSIS OF YOUR COMPLAINT? _____

_____

HAVE YOU EVER HAD ANY SURGERIES OF ANY TYPE? (IF SO LIST)

_____

DRUGS YOU NOW TAKE (PLEASE LIST):

_____

ANY CHIROPRACTOR CONSULTED IN THE PAST? □ YES □ NO
NAME_____
DATES CONSULTED_____FOR WHAT PROBLEM? _____

_____

IF YOU ARE A WOMAN—IS THERE ANY POSSIBILITY YOU ARE PREGNANT?
□ YES □ NO
IN ORDER TO DETERMINE THE NATURE & NEED OF YOUR CONDITION AND TO HELP US DEVELOP A TREATMENT PLAN, I CONSENT TO A HEALTH HISTORY AND EXAMINATION BY DR.BLOMERTH.
X RAYS REMAIN THE PROPERTY OF THIS CLINIC

PATIENT'S SIGNATURE_____DATE_____

CONSENT TO TREATMENT & PAYMENT

I understand and agree that health and accident policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that this Chiropractic Office will prepare any necessary reports and forms to assist me in making collections from the insurance company and that any amount authorized to be paid directly to this Chiropractic Office will be credited to my account on receipt. However, I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. 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.

I authorize any and all involved insurance companies to pay medical benefits to the undersigned physician for services provided to me.

PATIENT'S SIGNATURE_____DATE_____
GUARDIAN/SPOUSE'S SIGNATURE_____DATE_____
DOCTOR'S SIGNATURE_____DATE_____

CONSENT TO OFFICE OPERATIONS / RELEASE FORM

1. I authorize Blomerth Chiropractic to give/send reminder calls/cards. □ YES □ NO
2. I authorize Blomerth Chiropractic to use my name on a thank you for referral note.
   □ YES □ NO