

WELCOME TO WAYSON FAMILY CHIROPRACTIC, P.C.

Confidential Patient Information

Date _____
Name _____ SSN _____ Home Phone _____
Address _____ City _____ State _____ Zip _____
Email _____ Fax _____ Cell Phone _____
Age _____ Birth Date _____ Marital Status: M S W D Number of Children _____
Occupation _____ Employer _____ Office Phone _____
Spouse _____ Occupation _____ Employer _____
Emergency Contact _____ Phone _____ Address _____
Family Medical Doctor _____ Clinic _____ Phone _____

Purpose of this appointment/Symptoms _____

This injury will be filed as personal injury to: Auto Insurance Worker's Compensation N/A

Date symptoms appeared or accident happened _____ Have you ever had the same or a similar condition?

Yes ___ No ___ If yes, when and describe _____

Days lost from work ___ **Have you ever seen a Chiropractor?** ___ If so, whom did you see _____

Describe your diet _____ Tobacco Use: Never ___ or Amt per day _____

Please check all that apply. Do you now or have you ever suffered from:

- | | | | |
|---|--|---|--|
| GENERAL: ___ Allergies _____ ___ Convulsions ___ Dizziness/Fainting ___ Headaches ___ Numbness/Tingling | MUSCLE & JOINT: ___ Arthritis ___ Bursitis ___ Foot Trouble ___ Low Back Pain ___ Neck Pain/Stiffness ___ Pain between Shoulders ___ Sciatica ___ Shoulder Pain ___ Elbow/Wrist/Hand Pain ___ Hip Pain ___ Leg Pain ___ Knee Pain ___ Jaw Pain/TMJ ___ Cancer _____ | GASTRO-INTESTINAL: ___ Constipation ___ Diarrhea ___ Gall Bladder Trouble ___ Liver Disease ___ Hemorrhoids ___ Heartburn/Indigestion ___ Hernias ___ Colds/Sinus Infection ___ Earache/Ringing ___ Nosebleeds ___ Eye Pain Mental Illness: _____ | RESPIRATORY: ___ Asthma ___ Chronic Cough ___ Shortness of Breath ___ Spitting up Blood ___ Spitting up Phlegm ___ Wheezing GENITO-URINARY: ___ Kidney Disease ___ Bed Wetting ___ Infertility ___ Urgency/Frequent/ Painful Urination ___ Prostate Disease ___ Diabetes |
|---|--|---|--|

FEMALE PATIENTS: ___ Cramps or Backache ___ Menopausal Symptoms/ Hotflashes

What surgeries have you had? (Include dates) _____

Serious Illnesses (Include dates) _____

Have you been treated for any health condition in the past year? Yes___ No___ Describe _____

What medication, drugs or supplements are you taking? _____

Do you have health insurance? ___ YES ___ NO

Are you the primary cardholder? ___ YES ___ NO

Name of insurance company _____

Insured's Name _____ Is this a group or individual plan? _____

Insured's Birth Date _____ Insured's SSN _____

AUTHORIZATION & RELEASE:

I have answered the above questions to the best of my knowledge and understand that providing inaccurate information is dangerous to my health.

I also authorize payment of insurance benefits directly to Dr. Blake Wayson or Wayson Family Chiropractic, P.C. I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. I clearly understand and agree that I am personally responsible for payment of all services, which are rendered to me that my insurance company does not pay. I also understand that if I suspend or terminate my care and my treatment, any fees for professional services, which are rendered to me, will be immediately due and payable. Should my account become delinquent, I will be responsible for any interest (to accrue at the rate of 18% annually, commencing 30 days after the initial bill for services is issued), for collection fees, including but not necessarily limited to attorneys fees and court costs incurred in collection attempts on my account. I hereby authorize Wayson Family Chiropractic to release any information to my insurance company/attorney acquired in the course of my examination or care. I understand that a photocopy of the above assignment and authorization will be deemed as valid as the original.

Our goal is to bring better health to our community. The best way for us to reach others is through word of mouth & satisfied patient referrals. The greatest compliment a patient can give is a referral of friends and family.

How did YOU find our office or whom may we thank for your referral? _____

Patient/Guardian Signature _____ **Date** _____

Gift In Kind Athletes:

I authorize Dr. Wayson, of Wayson Family Chiropractic, to bill my health insurance carrier for the chiropractic care received. I further understand that any co-pay portion will not be billed to me during the established athletic season.

Patient/Guardian Signature _____ Date _____