

PATIENT INFORMATION

today's date ____/____/____

last name _____ first name _____

address _____

city _____ state _____ zip _____

email _____

_____/_____/_____ _____ male female
date of birth age

single married separated divorced minor partnered

occupation _____

employer / school _____

employer / school address _____

_____/_____/_____ _____
spouse's name spouse's date of birth

spouse's employer _____

whom may we thank for referring you? _____

CONTACT INFORMATION

home phone (_____) _____

office phone (_____) _____

cell phone (_____) _____

best number to reach you? _____

home office cell

IN CASE OF EMERGENCY, CONTACT

name _____

relationship _____

home phone (_____) _____

other phone (_____) _____

ACCIDENT INFORMATION

is this condition due to an accident? yes no

date of accident ____/____/_____

type of accident auto work home other

to whom have you made a report of your accident?

auto insurance employer other

attorney name (if applicable) _____

phone (_____) _____

INSURANCE INFORMATION

Who is responsible for this account? _____

Relationship to patient self spouse dependant other

Insurance Company _____

Policy/ Group _____

ASSIGNMENT AND RELEASE

I certify that I, and/or my dependents, have insurance coverage with _____ and assign directly to Tiburon Wellness Center all insurance benefits, if any payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

Tiburon Wellness Center may use my health care information and may disclose such information to the above named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services.

signature of patient / parent / guardian _____

please print name of patient / parent / guardian _____

_____/_____/_____ _____
date relationship to patient

OUR POLICY

Your insurance contract is a contract between you and your insurance company, not between the insurance company and Tiburon Wellness Center. **The total balance on your account is your responsibility** regardless of whether your insurance company pays or not, and **full payment is due at the time of your first visit.**

As a courtesy to our patients we will prepare and submit your insurance forms for direct reimbursement, if we accept assignment of your insurance benefits. However, you are required by law to pay your co-pay,

We require that you keep a current credit card number on file with us at all times. If your insurance company has not paid your account within 45 days, the balance will be automatically transferred to your credit card. A monthly finance charge of 1.5% will be added to unpaid balances after 60 days, accrued from the time of billing.

Unless canceled 24 hours in advance, we reserve the right to charge for missed appointments at the rate of a normal office visit.

Credit Card # for Pre-Authorization / Expiration Date _____

Signature of Card Holder _____

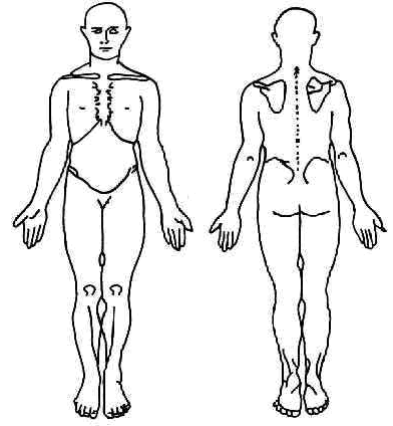
PLEASE CONTINUE ON OTHER SIDE

PATIENT CONDITION

Reason for your visit _____ When did your symptoms appear? _____

Is this condition getting progressively worse? yes no unknown

Indicate on the diagram where you are experiencing: sharp pain (xxx) aching (////)
stabbing (^^^)^ burning (***)
pins & needles (ooo) shooting (}}})



Rate the severity of your pain on a scale of 1 (least pain) to 10 (severe pain). _____

Type of pain?

- sharp dull throbbing numbness aching shooting
 burning cramps tingling stiffness swelling other

How often do you have the pain? constant intermittent other _____

Does your condition interfere with your? work sleep daily routine recreation

Painful activities/movements to perform? sitting standing walking bending lying down

HEALTH HISTORY

What treatment have you already received for your condition? none chiropractic acupuncture massage
 medication surgery physical therapy other _____

Name and address of other doctor(s) who have treated you for this condition _____

Date of last: physical exam _____ spinal x-ray _____ blood test _____
spinal exam _____ chest x-ray _____ urine test _____
dental x-ray _____ MRI/CT _____

Please mark "yes" or "no" to indicate if you have been diagnosed with any of the following:

AIDS/HIV	<input type="checkbox"/> yes <input type="checkbox"/> no	diabetes	<input type="checkbox"/> yes <input type="checkbox"/> no	measles	<input type="checkbox"/> yes <input type="checkbox"/> no	scarlet fever	<input type="checkbox"/> yes <input type="checkbox"/> no
alcoholism	<input type="checkbox"/> yes <input type="checkbox"/> no	emphysema	<input type="checkbox"/> yes <input type="checkbox"/> no	migraines	<input type="checkbox"/> yes <input type="checkbox"/> no	stroke	<input type="checkbox"/> yes <input type="checkbox"/> no
allergy shots	<input type="checkbox"/> yes <input type="checkbox"/> no	epilepsy	<input type="checkbox"/> yes <input type="checkbox"/> no	miscarriage	<input type="checkbox"/> yes <input type="checkbox"/> no	thyroid problems	<input type="checkbox"/> yes <input type="checkbox"/> no
anemia	<input type="checkbox"/> yes <input type="checkbox"/> no	fractures	<input type="checkbox"/> yes <input type="checkbox"/> no	mononucleosis	<input type="checkbox"/> yes <input type="checkbox"/> no	TIA	<input type="checkbox"/> yes <input type="checkbox"/> no
anorexia	<input type="checkbox"/> yes <input type="checkbox"/> no	glaucoma	<input type="checkbox"/> yes <input type="checkbox"/> no	multiple sclerosis	<input type="checkbox"/> yes <input type="checkbox"/> no	tonsillitis	<input type="checkbox"/> yes <input type="checkbox"/> no
appendicitis	<input type="checkbox"/> yes <input type="checkbox"/> no	goiter	<input type="checkbox"/> yes <input type="checkbox"/> no	mumps	<input type="checkbox"/> yes <input type="checkbox"/> no	tuberculosis	<input type="checkbox"/> yes <input type="checkbox"/> no
arthritis	<input type="checkbox"/> yes <input type="checkbox"/> no	gonorrhea	<input type="checkbox"/> yes <input type="checkbox"/> no	osteoporosis	<input type="checkbox"/> yes <input type="checkbox"/> no	tumors / growths	<input type="checkbox"/> yes <input type="checkbox"/> no
asthma	<input type="checkbox"/> yes <input type="checkbox"/> no	gout	<input type="checkbox"/> yes <input type="checkbox"/> no	pacemaker	<input type="checkbox"/> yes <input type="checkbox"/> no	typhoid fever	<input type="checkbox"/> yes <input type="checkbox"/> no
bleeding disorders	<input type="checkbox"/> yes <input type="checkbox"/> no	heart disease	<input type="checkbox"/> yes <input type="checkbox"/> no	parkinson's	<input type="checkbox"/> yes <input type="checkbox"/> no	ulcers	<input type="checkbox"/> yes <input type="checkbox"/> no
breast lump	<input type="checkbox"/> yes <input type="checkbox"/> no	hepatitis	<input type="checkbox"/> yes <input type="checkbox"/> no	pinched nerve	<input type="checkbox"/> yes <input type="checkbox"/> no	vaginal infections	<input type="checkbox"/> yes <input type="checkbox"/> no
bronchitis	<input type="checkbox"/> yes <input type="checkbox"/> no	hernia	<input type="checkbox"/> yes <input type="checkbox"/> no	pneumonia	<input type="checkbox"/> yes <input type="checkbox"/> no	venereal disease	<input type="checkbox"/> yes <input type="checkbox"/> no
bulimia	<input type="checkbox"/> yes <input type="checkbox"/> no	herniated disk	<input type="checkbox"/> yes <input type="checkbox"/> no	polio	<input type="checkbox"/> yes <input type="checkbox"/> no	whooping cough	<input type="checkbox"/> yes <input type="checkbox"/> no
cancer	<input type="checkbox"/> yes <input type="checkbox"/> no	herpes	<input type="checkbox"/> yes <input type="checkbox"/> no	prostate problems	<input type="checkbox"/> yes <input type="checkbox"/> no	OTHER	
cataracts	<input type="checkbox"/> yes <input type="checkbox"/> no	high cholesterol	<input type="checkbox"/> yes <input type="checkbox"/> no	psychiatric condition	<input type="checkbox"/> yes <input type="checkbox"/> no	_____	_____
chemical dependency	<input type="checkbox"/> yes <input type="checkbox"/> no	kidney disease	<input type="checkbox"/> yes <input type="checkbox"/> no	rheumatoid arthritis	<input type="checkbox"/> yes <input type="checkbox"/> no	_____	_____
chicken pox	<input type="checkbox"/> yes <input type="checkbox"/> no	liver disease	<input type="checkbox"/> yes <input type="checkbox"/> no	rheumatic fever	<input type="checkbox"/> yes <input type="checkbox"/> no	_____	_____

EXERCISE ROUTINE none moderate daily

WORK ACTIVITY sitting standing computer lifting

HABITS smoking (packs per day) _____
 alcohol (drinks per week) _____
 coffee/caffeine (cups per day) _____
 high stress level (reason) _____

are you pregnant? yes no Due Date _____

current medications _____

allergies _____

vitamins / supplements _____

INJURIES / SURGERIES

Description	date
falls	_____
head injuries	_____
broken bones	_____
dislocations	_____
surgeries	_____

