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IN EVENT OF EMERGENCY

Who should we contact? ______________________________

Relation: ______________________________

Home Phone #: ______________ Work Phone #: ______________

Who is your Medical Doctor? ______________ Phone #: ______________

HEALTH HISTORY

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Are you taking any of the following medications?

❑ Nerve pills ❑ Pain killers (including aspirin) ❑ Muscle relaxers ❑ Stimulants
❑ Blood Thinners ❑ Tranquilizers ❑ Insulin ❑ Other(s) ______________

Do you have or ever had any of the following diseases or conditions?

Y N Heart Attack / Stroke
Y N Congenital Heart Defect
Y N Alcohol / Drug Abuse
Y N HIV+ / Aids
Y N Frequent Neck Pain
Y N High/Low Blood Pressure
Y N Severe/Frequent Headaches
Y N Fainting/Seizures/Epilepsy
Y N Diabetes / Tuberculosis
Y N Lower Back Problems
Y N Heart Surg./Pacemaker
Y N Mitral Valve Prolapse
Y N Venereal Disease
Y N Shingles
Y N Emphysema / Glaucoma
Y N Psychiatric Problems
Y N Kidney Problems
Y N Sinus Problems
Y N Difficulty Breathing
Y N Artificial Bones / Joints
Y N Heart Murmur
Y N Artificial Valves
Y N Hepatitis
Y N Cancer
Y N Anemia
Y N Rheumatic Fever
Y N Ulcers / Colitis
Y N Asthma
Y N Chemotherapy
Y N Arthritis

Please list any other serious medical condition(s) you have or ever had:

____

Please list anything that you may be allergic to: ______________

____

List previous surgeries/treatments with dates: ______________

____

List any **past** serious accidents with dates: ______________

____

Family Health History: ______________

____

Do you: Take Supplements or Vitamins? ❑Yes ❑ No / Exercise? ❑Yes ❑ No

Are you on a special diet: ❑ Yes ❑ No / Since: ____/____/____

Do you smoke? ❑ No ❑ Yes / How Much? ________ How Long? ________

Are you wearing: ❑ Heel Lifts ❑ Sole lifts ❑ Inner soles ❑ Arch supports

What is the age of your mattress? _____ Is it comfortable? ❑ Yes ❑ No

For women: Are you taking Birth Control? ❑ Yes ❑ No

Are you Pregnant? ❑ No ❑ Yes/How long? _____ Nursing? ❑ Yes ❑ No

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ACCOUNT INFO

Person ultimately responsible for account

Name: ______________________________

Relation: ______________________________

Billing Address: ______________________________

____
CITY STATE ZIP

SSN: ______________________________

D.L.#: ______________________________

Work Phone#: ______________________________

Payment method: ❑ CASH ❑ Check

______________________________ /

❑ Credit Card - Enter card # above (if accepted)

______ Initials I hereby authorize assignment of my insurance rights and benefits directly to the provider for services rendered. I fully understand I am solely responsible for any balance not paid by my insurance company (if offered at this office).

- We invite you to discuss with us any questions regarding our services. The best health services are based on a friendly, mutual understanding between provider and patient.
- Our policy requires payment in full for all services rendered at the time of visit, unless other arrangements have been made with the business manager. If account is not paid within 90 days of the date of service and no financial arrangements have been made, you will be responsible for legal fees, collection agency fees, and any other expenses incurred in collecting your account.
- I authorize the staff to perform any necessary services needed during diagnosis and treatment. I also authorize the provider and or managed care organization, to release any information required to process insurance claims.
- I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes to the information I have provided.

Signature ______________________________ Date ____/____/____
❑ Adult Patient ❑ Parent or Guardian ❑ Spouse

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