____Patient I.D.

HEARTLAND FAMILY CHIROPRACTIC, PLLC

THANK YOU FOR CHOOSING HEARTLAND FAMILY CHIROPRACTIC, PLLC PLEASE COMPLETE ALL QUESTIONS.

NAME: _____ SOCIAL SECURITY #: _____

ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

PHONE #: _____ Email: _____ BIRTHDATE: _____

EMPLOYER: _____ EMPLOYER'S PHONE #: _____

MARITAL STATUS: M S W D PREGNANT? YES NO # OF CHILDREN: _____

NAME OF SPOUSE OR GUARDIAN_____ SPOUSE'S EMPLOYER: _____

NAME& SOCIAL SECURITY # OF PERSON RESPONSIBLE FOR THIS ACCOUNT_____

EMERGENCY CONTACT: _____ RELATIONSHIP: _____

PHONE#:_____ ALTERNATIVE PHONE #:_____

HOW DID YOU HEAR ABOUT OUR OFFICE? _____
IF YOU WERE REFERRED, WHOM MAY WE THANK? _____

IS THIS VISIT THE RESULT OF AN AUTO ACCIDENT OR WORK INJURY? YES OR NO
IF YES, DATE THAT THE INJURY OCCURRED _____ BRIEFLY DESCRIBE THE INCIDENT IN WHICH THE INJURY OCCURRED.
_____

_____

CURRENT HEALTH COMPLAINTS: **DATE STARTED OR HOW LONG/OFTEN?**

1._____ _____

2._____ _____

3._____ _____

FAMILY MEMBERS WITH SIMILAR PROBLEMS? YES OR NO IF SO, WHO? _____

MEDICAL DOCTORS OR CHIROPRACTORS YOU HAVE SEEN FOR THIS CURRENT PROBLEM:

NAME: _____ CONDITION: _____

NAME: _____ CONDITION: _____

NAME: _____ CONDITION: _____

HAVE YOU BEEN SEEN IN THIS OFFICE IN THE LAST THREE YEARS? YES OR NO
IF SO, FOR WHAT CONDITION? _____ DATE: _____

CURRENT MEDICATIONS: **PREVIOUS SURGERIES**

NAME: _____ PURPOSE: _____ TYPE: _____ DATE: _____

NAME: _____ PURPOSE: _____ TYPE: _____ DATE: _____

NAME: _____ PURPOSE: _____ TYPE: _____ DATE: _____

DO YOU HAVE HEALTH INSURANCE? YES OR NO
NAME OF YOUR INSURANCE COMPANY: _____
NAME OF THE POLICY HOLDER: _____ POLICY HOLDER'S BIRTH DATE: _____

THE ABOVE INFORMATION IS TRUE AND ACCURATE TO THE BEST OF MY KNOWLEDGE. I AUTHORIZE AND GIVE MY CONSENT FOR DR. FULKERSON AND HIS ASSISTANTS TO ADMINISTER CHIROPRACTIC CARE AS DEEMED NECESSARY AND TO TAKE ANY NECESSARY X-RAYS. I FURTHER UNDERSTAND AND AGREE THAT HEALTH AND ACCIDENT INSURANCE POLICIES ARE AN ARRANGEMENT BETWEEN AN INSURANCE CARRIER AND MYSELF. I AUTHORIZE THE RELEASE OF ANY MEDICAL OR OTHER INFORMATION NECESSARY TO PROCESS THIS CLAIM. I ALSO REQUEST PAYMENT OF GOVERNMENT BENEFITS EITHER TO MYSELF OR TO THE PARTY WHO ACCEPTS ASSIGNMENT. FURTHERMORE, I UNDERSTAND THAT HEARTLAND FAMILY CHIROPRACTIC, PLLC WILL PREPARE ANY NECESSARY REPORTS AND FORMS TO ASSIST ME IN MAKING COLLECTION FROM THE INSURANCE COMPANY AND THAT ANY AMOUNT OF AUTHORIZATION TO BE PAID DIRECTLY TO HEARTLAND FAMILY CHIROPRACTIC WILL BE CREDITED TO MY ACCOUNT UPON RECEIPT. HOWEVER I CLEARLY UNDERSTAND AND AGREE THAT **I AM PERSONALLY RESPONSIBLE FOR PAYMENT AND ANY COLLECTION AND/OR ATTORNEY FEES ASSOCIATED WITH MY ACCOUNT**.

_____ _____

PATIENT/ GUARDIAN SIGNATURE **DATE**