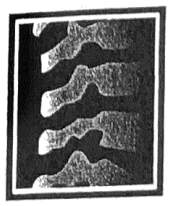

LAW CHIROPRACTIC

WELCOME

ACCOUNT NO._____

PATIENT INFORMATION

(Please Print)

NAME_____ SS#_____
First Middle Initial Last

ADDRESS_____ CITY_____ STATE_____ ZIP CODE_____

BIRTHDAY_____ SEX: MALE - FEMALE MARITAL STATUS: M S W D

HOME PHONE _____ CELL PHONE_____ E-MAIL_____

EMPLOYER _____ OCCUPATION_____ WORK PHONE_____

SPOUSE'S NAME_____ EMPLOYER_____ WORK PHONE_____

REFFERRED BY?_____ EMERGENCY CONTACT_____PHONE_____

INSURANCE INFORMATION

PRIMARY INSURANCE_____ EMPLOYER_____ CONTRACT #_____

NAME OF INSURED_____ DOB_____SS#_____

RELATIONSHIP TO PATIENT_____ PHONE_____

SECONDARY INSURANCE_____ EMPLOYER_____CONTRACT#_____

NAME OF INSURED_____ DOB_____ SS#_____

RELATIONSHIP TO PATIENT_____ PHONE_____

RESPONSIBLE PARTY (If different from above)

NAME OF PERSON RESPONSIBLE FOR THIS ACCOUNT_____

RELATIONSHIP TO PATIENT _____ PHONE_____

ADDRESS TO PATIENT_____ CITY_____ STATE_____ ZIP_____

EMPLOYER_____ OFFICE PHONE_____

HEALTH HISTORY

Present Symptoms? _____

Other Doctor's seen for this condition? _____

Please list any tests, procedures, or treatments you have had for this condition (MRI, CT, Surgery, Medication, Therapy, Injections) _____

Is this condition related to an auto accident? _____ Work Related? _____

List any Surgeries you have had and dates they were performed.

_____

_____

List any bone fractures, injuries or falls and dates they occurred.

_____

_____

Please list any medications or vitamins you are taking._____

_____

Do you smoke?_____How much per day?_____

Certification and assignment

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if I, or my minor child, ever have a change in health or change in insurance benefits. I certify that I, and/or my dependent(s) have insurance coverage with _____(name of insurance company) and assign directly to Dr Law all insurance benefits, if any, otherwise whether or not paid by insurance. I authorize the use of my signature on all insurance submissions. I understand and agree that health and accident insurance policies are an agreement between an insurance Carrier and myself. Furthermore, I understand that Law Chiropractic will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to Law Chiropractic 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. In the event I fail to pay the amounts when due. I understand that I will be in default of our agreement. Delinquency and default: I agree to pay the costs incurred to collect this bill in the event of my default in payment, including your reasonable attorney's fees.

_____ _____

Signature of patient, Parent, Guardian or Personal Representative Date

_____ _____

Please print name of Patient, Parent, Guardian or Personal Representative Date