

## PATIENT INFORMATION

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Please allow our staff to photocopy your driver's license and all available insurance cards.

**WELCOME! PLEASE PRINT.**

Full Name \_\_\_\_\_ Gender: **M F** Home Phone: \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Age \_\_\_\_\_ Birthdate \_\_\_\_\_ Marital Status (Circle One): **S M W D Sep** No. Children \_\_\_\_\_

SS#: \_\_\_\_\_ Driver's License # \_\_\_\_\_ Email Address \_\_\_\_\_

Your Employer \_\_\_\_\_ Your Occupation \_\_\_\_\_ Years on Job \_\_\_\_\_

Employer Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Work Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_ Emergency Contact \_\_\_\_\_ Tel #: \_\_\_\_\_

Do you have health insurance where you work?  Yes  No Insurance Co. Name/Group # \_\_\_\_\_

Insurance Company \_\_\_\_\_

Name of Spouse, Parent or Guardian \_\_\_\_\_ Age \_\_\_\_\_ Birthdate \_\_\_\_\_ SS# \_\_\_\_\_

Spouse's Employer \_\_\_\_\_ Spouse's Occupation \_\_\_\_\_ Yrs on Job \_\_\_\_\_

Employer Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Tel #: \_\_\_\_\_

Does your spouse have health insurance at work?  Yes  No Insurance Co. Name/Group # \_\_\_\_\_

How did you find out about our office:  Sign  Friend/Family  Phonebook  Newspaper  Other \_\_\_\_\_

If a person, please tell us who it is, so we may thank them for referring you to our office: \_\_\_\_\_

I, the undersigned, hereby authorize Dr. Kristi Mauldin and whomever she may designate as her assistant(s) to perform diagnostic tests including but not limited to radiographs, and to administer treatment as necessary. I also certify that no guarantee or assurance of results can be obtained.

I (we) agree to pay for services rendered to the above-mentioned patient as the charge is incurred. I (we) understand that health and accident insurance policies are arrangements between and insurance carrier and myself and that I am personally responsible for payment of any and all services, covered and non-covered. If the doctor is a contracted provider for my managed care plan, I understand I am responsible for all copayments and non-covered services. I also understand and agree to pay all copays and fees for non-covered services prior to seeing the doctor. I understand that if I terminate my care and treatment, any fees for professional services rendered me will be immediately due and payable. I understand that unpaid fees for services beyond thirty (30) days are subject to a 1.5% monthly finance charge (18% annually), unless I have a pre-arranged financial arrangement with the office and I am currently still under care.

I (we) authorize the doctor and her staff to release any information deemed appropriate concerning my physical condition to any insurance company, claims adjuster, case nurse, claims reviewer, employer, health care provider or attorney in order to process any claim for reimbursement or charges incurred by me as a result of professional services rendered and hereby release him/her of any consequences thereof. I agree that a photostatic copy of this agreement shall serve as the original.

I (we) hereby authorize and direct payment by any insurance company or attorney for all medical/chiropractic expense benefits allowable to Lexington Family Chiropractic Center, P.A. as payment toward the total charges for professional services rendered. I fully understand that I am directly responsible for all medical bills and this agreement is made solely for the doctor's additional protection and consideration of her awaiting payment. I agree that a photostatic copy of this agreement shall serve as the original.

I hereby request and authorize all doctors, hospitals, and health professionals that I have seen or will see to furnish this office with all copies of records and reports, including copies of X-rays and photostatic copies, abstracts or excerpts of all records and any other information requested relating to any examination, treatment or opinion concerning any condition that I have had in the past, now have, or may have in the future. Please forward this to: Dr. Kristi Mauldin, 215 W. U.S. Hwy 64, Suite 1, Lexington, NC 27295; (336)243-5433 Tel: (336)243-5435 Fax.

Patient's Signature \_\_\_\_\_ Date \_\_\_\_\_

Spouse's or Guardian's Signature \_\_\_\_\_ Date \_\_\_\_\_

**We file your insurance at no charge to you.** Payment Options (Please Indicate):  Cash/Debit Card  Check  MC/Visa  Discover

**PATIENT CONDITION**

**NAME**

**DATE**

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Reason for today's visit: \_\_\_\_\_

Is your condition due to an accident?  Yes  No Date of your accident: \_\_\_\_\_

Type of Accident:  Auto  Work  Home  Other \_\_\_\_\_

To whom have you made a report of your accident?  Auto  Work  Home  Other \_\_\_\_\_

Attorney Name (if applicable): \_\_\_\_\_ Tel. No. \_\_\_\_\_

When did your symptoms appear? \_\_\_\_\_

Is this condition getting progressively worse?  Yes  No  Unknown

Rate the severity of your pain on a scale from 1 (least pain) to 10 (severe pain) \_\_\_\_\_

Type of pain:  Sharp  Dull  Throbbing  Numbness  Aching  Shooting  
 Burning  Tingling  Cramps  Stiffness  Swelling  Other

Is the pain constant or does it come and go? \_\_\_\_\_

Does this interfere with your:  Work  Sleep  Daily Routine  Recreation/Hobbies

Activities or movements that are painful to perform:  Sitting  Walking  Bending  Lying Down

Please mark an 'X' on the picture where you continue to have pain, numbness, tingling or any sensation.

Why Chiropractic? People go to chiropractors for a variety of reasons. Some go for symptomatic relief of pain or discomfort (Relief Care). Others are interested in having the cause of the problem, as well as the symptoms, corrected and relieved (Corrective Care). Still, others want whatever is malfunctioning in their bodies brought to the highest state of health possible with Chiropractic care and other alternative methods (Comprehensive Care). Your Doctor of Chiropractic will weigh your needs and desires when recommending your treatment program.

Please check the type of care desired by you, so that we may be guided by your wishes whenever possible.

\_\_\_\_\_Relief Care    \_\_\_\_\_Corrective Care    \_\_\_\_\_Comprehensive Care    \_\_\_\_\_Check here if you  
want the Doctor to  
select the type of  
care appropriate.