APPLEWAY CHIROPRACTIC
213 W. Appleway Ste. 7 Coeur d Alene, Id. 83815
208-666-1000

GENERAL INFORMATION TODAY'S DATE_____

Name: First_____Middle_____Last_____

Address_____City_____St._____Zip_____

Home Ph._____Work Ph ._____Cell Ph._____

Date of Birth_____ **Social Security #_____-_____-_____**

Circle one for each of the following:

Sex: Male Female

Marital Status : Married Single Widowed Divorced Other

Employed: Full Time Part Time Not Employed

Student: Full Time Part Time Not Enrolled

Billing: Cash Insurance

Referred By:_____

CONDITION INFORMATION

Is This Injury Related To An Auto Accident?_____or Employment? _____Other?_____
Date of Accident_____Consult Date_____Similar Symptoms_____
What Doctors Have You Seen For This Condition?_____
Progress: Better_____Worse_____Other_____
What Makes the Condition Worse?_____
have You Ever Been Hospitalized ?_____If so, When and Why?_____
Had Surgery?_____If so, When and What Kind of Operations_____
Had a Major or Minor Fall or Accident Yes____ No____
Are You Pregnant At This Time? Yes or No Birth Control Pills? Yes or No
Date of Last Menstrual Cycle_____ regular_____ irregular_____
Personal Habits: Tobacco_____Alcohol_____Vitamins_____Exercise_____
Medications Taken At This Time_____
_____
_____

PRESENT HEALTH PROBLEMS
Please List below the 5 or more complaints you have in the order of importance.
Also the length of time you have had these complaints.
1._____How Long?_____
2._____How Long?_____
3._____How Long?_____
4._____How Long?_____
5._____How Long?_____

EMPLOYER INFORMATION

Your Employer
Employer_____
Address_____
City_____St._____Zip_____
Contact_____
Phone_____

Spouse Employer
Employer_____
Address_____
City_____St._____Zip._____
Contact_____
Phone_____

INSURED'S INFORMATION
Relationship to Insured: Self Spouse Child Other **Insured:** Male or Female
Name of Insured: First_____Middle_____Last_____
Address of Insured:_____City_____St._____Zip_____
Phone Number_____S.S.N of Insured_____-_____-_____ **Date of Birth**_____

INSURANCE INFORMATION
Primary Insurance
Name_____
Attn.:_____
Address_____
City_____St_____Zip_____
Contact_____
Phone_____
Fax_____
Plan Name_____
Insurance ID#_____
Group #_____

Secondary Insurance
Name_____
Attn.:_____
Address_____
City_____St._____Zip_____
Contact_____
Phone_____
Fax_____
Plan Name_____
Insurance ID#_____
Group #_____

GUARANTOR(if other than patient)
Name_____Home Ph._____Work Ph._____
Address_____City, State, Zip_____
Social Security #_____-_____-_____

I understand and agree that the health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that the Doctor's office 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 the Doctor's office 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. I hereby authorize the Doctor to treat my condition as he deems appropriate through the use of manipulation throughout my spine. It is understood and agreed that the amount paid the Doctor, for x-rays, is for examination only and the x-ray negatives will remain the property of this office, being on file where they may be seen at any time while a patient is in the office. THE DOCTOR WILL NOT BE HELD RESPONSIBLE FOR ANY PRE-EXISTING MEDICALLY DIAGNOSED CONDITION, NOR FOR ANY MEDICAL DIAGNOSIS.
I authorize payment of medical benefits to Appleway Chiropractic.
I authorize the Doctor to treat me.

Patient Signature_____ Date_____

Parent / Guardian Signature_____Date_____