

BERTELSMAN CHIROPRACTIC

NEW PATIENT INFORMATION

Name _____ Female Male Date _____

What you prefer to be called _____ Age _____ Occupation _____

Address _____ City _____ State _____ Zip _____

Birth date _____ SS# _____ Home phone _____

Employer _____ Work phone _____

Emergency contact _____ Phone _____

E-Mail Address _____ Cell phone _____

Referred By _____ When did your condition begin? _____

Is your condition due to an Automobile Accident? Yes No

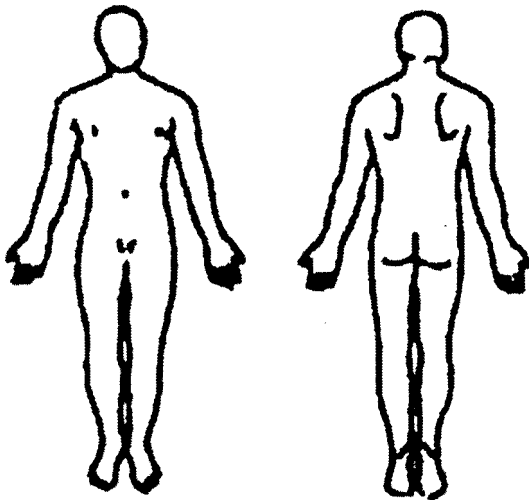
Is your condition due to an Employment Related Injury? Yes No

If so, have you reported it? Yes No

Days lost from work _____ Other Doctors seen for this condition _____

Have you had the same or similar symptoms before? Yes No Approx. Date of prior condition _____

Mark Areas of Pain on Figures Below



List chief symptoms in order of severity

(1) _____

(2) _____

(3) _____

Have you had chiropractic care before? Yes No

Family physician _____

Date of last physical _____

May we forward our findings to your family physician? Yes No

Are you currently taking any medications? _____

Previous surgeries _____

Do you have a personal history of Cancer Diabetes Heart Disease Stroke

Other serious illnesses _____

Check all symptoms that apply to you

Headache Numbness in toes Chest Pain Unexplained weight loss

Neck Pain Tingling Legs Arthritis Fever

Neck Stiffness Loss of balance Shortness of breath Fatigue

Tingling in Arms Dizziness Back Pain Night Sweats

Numbness in hands Irritability Sinus Trouble Blood in Urine

Shoulder Pain Knee Pain Hip Pain Night Pain

Other _____ Pain unrelieved by rest

For women: are you pregnant? Yes No

Are you taking birth control? Yes No

Payment is expected at time of visit. Method: Cash Check Mastercard/Visa

Do you have health insurance? Yes No Company Name _____

Policy holder Name _____ Relationship to policy holder: Self/Spouse/Child

Policy # _____ Phone _____

Secondary Insurance Name _____ Relationship to policy holder: Self/Spouse/Child

Policy # _____ Phone _____

Auto Accident Insurance Name _____ Adjuster _____

Claim # _____ Phone _____

Worker's Compensation Claim Supervisor _____ Phone _____

INSURANCE INFORMATION, CONSENT OF PROFESSIONAL SERVICES AND
RELEASE OF INFORMATION

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore I understand that this chiropractic 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 this chiropractic office will be credited to my account on receipt. However, I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. I also understand if I suspend or terminate my care and treatment, any fees for professional services rendered to me will be immediately due and payable.

I hereby authorize Dr. Timothy J. Bertelsman or Dr. Cory Hultman and whomever they may designate as their assistants to administer treatment, physical examination, X-ray studies, laboratory procedures chiropractic care, or any clinic services that they deem necessary in my case; and I further authorize them to disclose all or any part of my (patient's) record to any person or corporation which is or may be liable under a contract to the clinic or to the patient or a family member or employer of the patient for all or part of the clinic's charge, including, and not limited to hospital or medical services companies, insurance companies, workers compensation carriers, welfare funds, or the patient's employer.

We invite you to discuss with us, any questions you might have. The best health services are based on a friendly, mutually understood relationship.

Patient's or Guardian's Signature: _____ Date _____