

Tipp City Chiropractic Center
215 S. Garber Drive, Tipp City, OH 45371
(937) 667-7700 (p) ~ (937) 667-5189 (f)

Date: _____

Confidential Patient Information

Patients Name: _____	Chief Complaint: _____
Address: _____	Home Phone: _____
City: _____ Zip: _____	Cell Phone: _____
SS#: _____	Email: _____
Date of Birth: _____ Age: _____	Marital Status: M S W D # of Children: _____
Occupation: _____	Employer: _____
Address of Insured (if different than above): _____	
Are your present systems or condition related to, or the result of an auto collision, work-related injury or other personal injury? (Someone else might be responsible for payment?) ___ Yes ___ No	
Ins. Company: _____	Ins. Phone #: _____
ID#: _____	Group #: _____
Name of Policy Holder: _____	Policy Holder DOB: _____
Policy Holders Employer: _____	

Family Physician: _____ (Note: May we send your health information to this provider Y / N)

Person to contact in case of emergency (Name and Phone): _____

Have you ever been under Chiropractic Care? Y N If so, Who & When? _____

Have you had any SPINAL X-Rays / MRI's / CT's taken in the last year? Y N If so, Where? _____

What operations have you had? _____ When? _____

Serious Illness: _____ When? _____

Infectious Diseases: _____ When? _____

Do you have a pace maker? Y / N Have you ever had any Hip or Knee Replacements Y / N

Are or were you a smoker? Y / N If yes, for how long? _____ When did you quit? _____

What medications or drugs are you taking? (check those that apply): Pain Killers ___ Insulin ___ Cholesterol Meds ___
Blood Pressure Meds ___ Muscle Relaxers ___ Birth Control ___ Other: _____

Do you have a Family History of:
Mother's Side: Cancer ___ Type: _____ Diabetes: Type 1 ___ Type 2 ___ Stroke ___ Cardiovascular ___ Other ___
Father's Side: Cancer ___ Type: _____ Diabetes: Type 1 ___ Type 2 ___ Stroke ___ Cardiovascular ___ Other ___

What is your goal in our office? _____

LEGAL ASSIGNMENT OF BENEFITS AND RELEASE OF MEDICAL AND PLAN DOCUMENTS

In considering the amount of medical expenses to be incurred, I, the undersigned, have insurance and/or employee health care benefits coverage with the above captioned, and hereby assign at clinic's request, and convey directly to **Tipp City Chiropractic Center** all medical benefits and/or insurance reimbursement, if any, otherwise payable to me for services rendered from such doctor and clinic. I understand that I am financially responsible for all charges regardless of any applicable insurance or benefit payments. I hereby authorize the doctor to release all medical information necessary to process this claim. I hereby authorize any plan administrator or fiduciary, insurer and my attorney to release to such doctor and clinic any and all plan documents, insurance policy and/or settlement information upon written request from such doctor and clinic in order to claim such medical benefits, reimbursement or any applicable remedies. I hereby authorize the doctor to release any and all medical information to other healthcare providers involved in my care including but not limited to my primary care physician. I authorize the use of this signature on all my insurance and/or employee health benefits claim submissions.

This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original. I have read and fully understand this agreement.

Signature of Insured / Guardian

Date