Innate & Hyack Family Chiropractic LLC

PERSONAL INFORMATION

How did you hear about us? ____

Name: ______________________________ Height ______Weight ______ Today's Date: _____/_____/_____

Nickname: ___________________ Birth date: _____________ Age: _____ SS#: ______________________

Home Address: ____
(STREET) (CITY) (STATE) (ZIP)

Home Phone #: ______________________________ Work Phone #: ______________________________

Cell Phone #: ______________________________ Occupation: ______________________________

Employer: _________________________How Long? ________ Job Duties_________________________

Employer Address: ____
(STREET) (CITY) (STATE) (ZIP)

Spouse's Name: ______________________________Number of Children_________________________

Emergency Contact (NAME): ___________________________ (PHONE #): ___________________________

Email Address (For Internal Newsletter, Not Sold): ____

PATIENT CLINICAL PROFILE:

Health complaint/symptoms: ____

____

Previous treatments, medications, surgeries (RELATED TO COMPLAINT): ______________________________

____

Prior Chiropractic Experience: ____

____

PAST HEALTH HISTORY:

Overall health status: 1 2 3 4 5 6 7 8 9 10
(WORST) (BEST)

Previous Illnesses: ____

Surgeries: DATE TYPE OF SURGERY

__________ ____

__________ ____

Previous injury or trauma: ____

____

Are you taking (please list) any medications? ______________________________________

____

Have you had any difficulties with any of the following systems or organs?

___ Cardiovascular/ Heart/ Blood ____ Digestive/ Bowel ___ Immune System
___ Nervous System ____ Lymph System ___ Hepatic/ Liver
___ Pulmonary/ Lung ____ Brain/ Head ___ Skin, Hair, Nails
___ Reproductive ____ Musculoskeletal ___ Urinary Tract/ Kidney
___ Eyes, Ears, Nose, and Throat ____Other: ___________

Allergies: ___________

What do you enjoy doing most in life? ___________

____

Lifestyle (HOBBIES, LEVEL OF EXERCISE, DIET, TOBACCO, ALCOHOL, ETC.): ___________

____

Are you wearing: ☐ Heel Lifts ☐ Sole Lifts ☐ Inner Soles ☐ Arch Supports

Is there anything not listed that you feel this office should be aware of? ___________

____

FOR WOMEN: Are you taking birth control? ☐Yes ☐No
Are you pregnant? ☐Yes ☐No ☐ Maybe Nursing? ☐Yes ☐No

INSURANCE INFORMATION:

Primary Insurance Co: ___________ Group #: ___________
Insured's name: ___________ Relationship to Insured: ___________
Insured's Birth date: ___________ Insured's SS#: ___________

Secondary Insurance Co: ___________Group #___________
Insured's name: ___________ Relationship to Insured: ___________
Insured's Birth date: ___________ Insured's SS#: ___________

Assignment & Release

I, the undersigned, certify that I (or my dependent) have insurance coverage with ___________ and assign directly to Dr. Jeffrey Hyack all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

___________ ___________ ___________
RESPONSIBLE PARTY SIGNATURE RELATIONSHIP DATE

EVERYONE

♦We invite you to discuss with us any questions regarding our services. The best health services are based on a friendly, mutual understanding between provider & patient.
♦Our policy requires payment in full for all services rendered at the time of visit, unless other arrangements have been made with our office. If your account is not paid within 90 days of the date of service and no financial arrangements have been made, you will be responsible for any expenses incurred in collecting your account.
♦I authorize the staff to perform any necessary services needed during treatment.
♦I understand the above information and guarantee this form was completed correctly to the best of my knowledge & understand it is my responsibility to inform this office of any changes in the status of my health.

SIGNATURE___________ DATE ______/______/______