Welcome To Our Office

Last Name	First Name	MI	Today's Date

Age	Date of Birth	Sex Male Female	Marital Status

Street Address	City	State	Zip Code

E-Mail Address

Name of Emergency Contact	Emergency Contact Telephone Number

Preferred Contact Method

Cell/Mobile Number ______________________ Carrier ______________________

Home Telephone Number ______________________

Work Telephone Number ______________________

Would you like appointment reminders via Text or E-Mail?

Yes Text Yes E-Mail No Thanks

Whom do we thank for referring you to our office?

Webpage/Internet Yellow Pages

Referral from Family/Friend ______________________

Referral from Doctor ______________________

Other ______________________

To Which Doctor?

Dr. Heitman Dr. Sellers

Employer

Office Policy

Our office motto is *"to treat you as we would want to be treated ourselves"*. We are happy to have you as a patient whether you have insurance or not. If you do not have insurance we are able to offer you our Medicare fee rate. If you do have insurance we will accept insurance assignment only if your insurance company has been pre-authorized by the office staff. Otherwise, fees for services are expected to be paid in full at the time of service. We accept Cash, Checks, Debit Cards, MasterCard, Visa, American Express, and Discover. Notice: all delinquent accounts over 60 days will receive a $10.00 per month additional accounting fee.

Patient Initials ______________

If you have **HEALTH INSURANCE** or your problem is a result of an **AUTO ACCIDENT or WORK-RELATED INJURY** please speak with the office staff prior to any consultation with the DOCTOR.

PATIENT CONDITION HISTORY FORM

What is the purpose of your visit? ______________________________

Approximately how long have you had this condition? ______________

Have you had similar problems in the past? No Yes, When? ________

What do you think caused this problem? __________________________

What activities aggravate your condition? _________________________

What have you done to make it better? ___________________________

Does your pain radiate or extend to other areas? No Yes, into my ________

Is this condition getting worse? Yes Comes and goes Stays the same

This condition limits my ability to: Work Sleep Daily Activities? ________

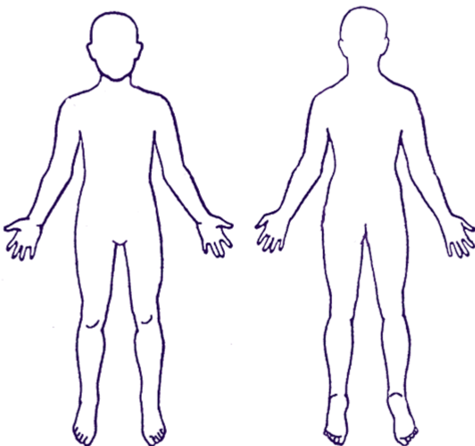
What would you like to be able to do that your condition currently limits? ________

Have you seen another Doctor for this condition? No Yes

Doctor's Name: ________________ Diagnosis: ________________

Treatment: ______________________________

PLEASE MARK YOUR AREAS OF PAIN ON THE FIGURES BELOW.



List past Surgical Operations with approximate dates:

____
____
____
____

List other complaints: ____
____
____

List Medications if any:	Purpose?
______________________	______________________
______________________	______________________
______________________	______________________
______________________	______________________
______________________	______________________
______________________	______________________
______________________	______________________
______________________	______________________

Do you personally have any history of the following: (please check all that apply)

Aneurysm	Cancer	Diabetes
Heart Disease	HIV+	Neck or Back Surgeries
Osteoporosis	Stroke	Tuberculosis

Have you ever seen a Chiropractor before? No Yes

If yes approximate date of last treatment ______________________

For Women Only: Are you pregnant? No Yes – Due Date __________

To help us better explain your chiropractic condition and how we may be able to benefit your needs, Please answer the following:

What are your goals for care?

Symptomatic pain relief only

Correction of the problem

Wellness care

Consent to Chiropractic Services

I authorize the performance upon myself or upon my named child ____________________________

The following procedures the Doctor deems necessary:

> *Chiropractic examination, spinal adjustments, intermittent traction, ice therapy, light therapy, ultrasound, muscle stimulation therapy, and/or x-rays* if needed.

I understand the nature and purpose of the procedures, possible alternatives, and the risks involved will be explained to me by the Doctor before treatment occurs. I also understand that I, as a patient, am responsible to ask the Doctor any questions or concerns regarding treatment procedures in this office.

I understand that my health information will be kept private and that I do have rights to that information upon request. An informational booklet is available at this office for review on how we use your information.

____ ________________________

Patient or Authorized Signature Date