

Acct# \_\_\_\_\_

F/C \_\_\_\_\_

**APPLICATION FOR TREATMENT**

First Name \_\_\_\_\_ MI \_\_\_\_\_ Last Name: \_\_\_\_\_

Mailing Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Home Phone (\_\_\_\_\_) \_\_\_\_\_ Work Phone: (\_\_\_\_\_) \_\_\_\_\_ Cell Phone: (\_\_\_\_\_) \_\_\_\_\_

Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_ Age \_\_\_\_\_ Sex  Male  Female

E-Mail \_\_\_\_\_ Social Security# \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Marital Status (please circle)    Single    Married    Widowed    Separated    Divorced

How were you referred to our office? \_\_\_\_\_

Employment Status (please circle)    Employed    Self Employed    FT Student    PT Student    Retired    Other

Your Employer \_\_\_\_\_ Occupation \_\_\_\_\_

Spouse Name \_\_\_\_\_ Number of Children \_\_\_\_\_

**METHOD OF PAYMENT**

Please check and sign the method you prefer to use to pay for services rendered to you:

- \_\_\_\_\_ I have no applicable health insurance and will pay for services with cash, check, or credit card.
- \_\_\_\_\_ I have health insurance (please give appropriate cards to our staff so we can verify your coverage specifics)
- \_\_\_\_\_ I have been injured on the job and will be filing Worker's Compensation
- \_\_\_\_\_ I have been injured in an auto accident

**REQUIRED IF FILING HEALTH INSURANCE**

Patient's Relationship to Primary Insured (please circle)    Self    Spouse    Child    Other    Employee

Primary Insured's Name \_\_\_\_\_

Primary Insured's Address \_\_\_\_\_

Primary Insured's Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_

Primary Insured's Employer Name \_\_\_\_\_

Name of person responsible for account (if different from applicant) \_\_\_\_\_

I hereby authorize **McLaughlin Chiropractic Center** to examine me, including x-rays if indicated by the exam and to release my records to anyone I designate. I further authorize treatments deemed necessary by the findings and I wish that all my chiropractic records be held in strict confidence and not to be given to anyone without my written consent. I authorize payment directly to the doctor from my insurance company and I clearly understand that I am totally responsible for payment should my insurance company deny payment or make payment to me.

BY SIGNING YOUR NAME BELOW YOU CERTIFY THE ACCURACY OF YOUR MEDICAL AND/OR ACCIDENT HISTORY AND FURTHER CERTIFY THAT YOU PRESENT TO **DR. MCLAUGHLIN** and whom he designates his Associates FOR EVALUATION AND/OR TREATMENT OF A HEALTH RELATED CONDITION AND FOR NO OTHER PURPOSE.

**FIRST VISIT FEES ARE DUE AND PAYABLE AT THE TIME OF SERVICE.**

Signature \_\_\_\_\_

Date \_\_\_\_/\_\_\_\_/\_\_\_\_

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Race (please circle)

White    Black/African American    Hispanic    Asian    Asian Indian    Chinese    Japanese    Other

I choose not to specify

Multi-Racial (check one)     Yes     No     Unknown

Ethnicity (check one)     Hispanic or Latino     Not Hispanic or Latino     I choose not to specify

Preferred Language (check one)     English     Spanish     Other (please specify) \_\_\_\_\_

Verification Question (choose only one question by circling the question, then give the answer to that question)

- What is the name of your favorite pet?     In what city were you born?     What high school did you attend?
- What is your favorite movie?     What is your mother's maiden name?     On what street did you grow up?
- What was the make of your first car?     When is your anniversary?     What is your favorite color?

Verification Answer to the Chosen question: \_\_\_\_\_

Do you currently smoke tobacco of any kind?     Yes     Former Smoker     Never been a smoker

If yes, how often do you smoke:     Current every day smoker     Current sometimes smoker

If yes, what is your level of interest in quitting smoking? (please circle)

No Interest    0    1    2    3    4    5    6    7    8    9    10    Very Interested

Current Medications (include dosage if known)    If there are no current medications, check here:

- 1) \_\_\_\_\_ 5) \_\_\_\_\_
- 2) \_\_\_\_\_ 6) \_\_\_\_\_
- 3) \_\_\_\_\_ 7) \_\_\_\_\_
- 4) \_\_\_\_\_ 8) \_\_\_\_\_

List any known allergies you have had to any medications.    If no allergies are known, check here:

- 1) \_\_\_\_\_ 3) \_\_\_\_\_
- 2) \_\_\_\_\_ 4) \_\_\_\_\_

Has any Doctor diagnosed you with Hypertension presently?     No     Yes    If yes, describe: \_\_\_\_\_

Has any Doctor diagnosed you with Diabetes presently?     No     Yes    If yes, what kind?     Type 1     Type 2

If yes to Diabetes, was your blood lab-work test for hemoglobin A1c > 9.0%?     No     Yes     Not Sure

If yes, other comments regarding Diabetes: \_\_\_\_\_

Have you had an X-ray or CT scan or MRI of your low back spine in the past 28 days?    No     Yes