

APPLICATION FOR TREATMENT

Acct. #: _____
FC: _____

Social Security Number: _____ Date of Birth: _____ Age: _____

Last Name: _____ First Name: _____ Middle Initial: _____

Street Address and Number: _____

Mailing Address (if different) _____

City, State and Zip Code: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Spouse's Name: _____ EMAIL ADDRESS: _____

Circle One: Married Single Widowed Divorced # of Children: _____

Sex: Male Female

Employer: _____ Occupation: _____

Employer Address: _____

Employer Phone: _____ Supervisor: _____

**Who referred
you to our
office?**

Have you ever
been a patient at
this office or one
of our other
offices?
YES NO

TYPE OF CARE YOU ARE REQUESTING (CHECK ONE):

- _____ WELLNESS CARE
(Available to people with no symptoms and no chronic spine injury who desire periodic spinal care for themselves and their family. This maintains the spine and nervous system and prevents avoidable illnesses. Recommended for infants and children.)
- _____ INITIAL ACTIVE CARE*
(For people with symptoms and chronic spinal conditions who want pain relief and initial spinal healing/stabilization.) *APPLIES TO MOST PATIENTS
- _____ RELIEF CARE
(Sufficient care to produce acute symptom relief only.)
- _____ NOT SURE OF THE TYPE OF CARE I NEED.

In case of an emergency, please contact (name, address, and phone number):

YOUR FAMILY MEDICAL DOCTOR: _____

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 my 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 Medicaid (Please give your card to our staff)

_____ I have Medicare (Please give your card to our staff)
If Medicare, do you have a supplemental insurance that we can verify?

_____ I have been injured on the job and will be filing Worker's Compensation

_____ I have been injured in an auto accident

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 all my chiropractic records to 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