APPLICATION FOR CHIROPRACTIC CARE
WELCOME TO OUR OFFICE

Name:______________________________ Home Phone:______________
Social Security Number__________________ Work Phone:______________
Address:____________________________________ Cell Phone:______________
City:____________________ State:______________ Zip Code:______________
Date of Birth:______________ Sex: M F Occupation:______________________
Marital Status: ___Married ___Single ___Widowed ___Divorced
How did you hear about our office? ______________________________________
Past Chiropractic Care Received: (when and where)
____
Have you been seen for any health condition by a doctor other than a chiropractor in the Last year? ___Yes ___No If yes explain:______________________________
____
Do you have a family physician? ___Yes ___No
What brought you to our office? _____Wellness Care _____ A condition, Please Explain
____
Dates you first noticed
them:____
Are the above complaints the result of an accident or injury? ___Yes ___No
If you do not have a specific problem but are here for health maintenance, check here:
______
List ALL surgeries, falls, accidents, and injuries you have had and give the date:
____
____
____
Drugs you are currently taking: (Include prescription and non-prescription drugs, such as birth control, aspirin, heart medicine, laxatives, cold tablets, etc.)

Type:	Purpose:
______________________	______________________
______________________	______________________
______________________	______________________

Please check the type of care you desire so that we may be guided by your wishes when Possible:
___ I prefer the doctor to select the type of care he feels is best for me.
___ Maximum improvement and prevention in the future.
___ Temporary relief for this specific problem.

Who is responsible for your bill?
You___ Spouse___ Worker's Comp___ Auto Insurance___ Medicare____
Personal Insurance (Name of Company)____________________________

Please initial:
_____ I understand that **payment is due in full each visit**. I understand that if I have insurance, it may or may not cover chiropractic services. Fees are listed on the back of this sheet.

Chiropractic Summary

Chiropractic care in our office is the art and science of detecting misaligned bones in the spine and reducing the pressure on the nerves they are pinching via spinal adjustments. This allows the body to function more appropriately and results in a healthier person. We do not and cannot detect any other conditions, illnesses, or diseases. Furthermore, we do not need to take x-rays to determine if spinal bones are misaligned. Thus, we cannot detect the presence of fractures. If you have had a major accident or injury severe enough that you suspect the possibility of a fracture or other medical conditions, we always suggest you first consult a medical doctor or visit the hospital to rule out such conditions. By signing below, you understand this summary and have either not had a severe injury/accident or have had a severe injury/accident but have already consulted a medical doctor and after their diagnoses have now decided you wish to have us determine if you have any spinal misalignments which are pinching upon spinal nerves.

Signed:____________________ Date:____________

Parent or Guardian's Signature authorizing care:
__________________________ Date:____________

Insurance Questionnaire

1. Is your chief complaint related to current or previous employment? Yes____ No____

2. Is your chief complaint related to an auto accident? Yes____ No____

Patient's or Authorized Person's Signature: I authorize the release of any medical or other information necessary to process my insurance claim. This is to serve as a long-term authorization card.
Signed____Date________________

Insured's or Authorized Person's Signature: I authorize payment of medical benefits to Kimbr Enterprises, Inc. for the services described on the insurance form. This authorization is to apply to all occasions of service until it is revoked in writing.
Signed____Date________________

Advanced Chiropractic Center Fees:

1st Visit	Subsequent Visits
Exam & Consultation: $40 Adjustment: $50 Medicare Adjustment $35 Child Adjustment (12 & under): $30	Adjustment: $50 Medicare Adjustment $35 Child Adjustment (12 & under): $30