

DAY CHIROPRACTIC CLINIC, P.S.

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CONFIDENTIAL PATIENT INFORMATION

Patient Name _____

Address _____ City _____ St _____ Zip _____

Social Security # _____ Sex **M** **F** Marital Status: **S** **M** **D** **W**

Patient Birthdate _____ Age _____ Spouse Name _____

Hm Phone (____) _____ Wk Phone (____) _____ Cell Phone _____

Please indicate the best contact number to reach you in case of a schedule change? Hm Wk Cell

Email Address _____

Name and number of emergency contact **NOT LIVING WITH YOU:**

Name _____ **Phone Number** _____

Your employer _____ Occupation _____

Employer address _____ City _____ St _____ Zip _____

Who may we thank for referring you to our office? _____

Is this a work accident? _____ Automobile accident? _____ Health insurance? _____

INSURANCE INFORMATION FOR THIS CONDITION: Are you the subscriber? Yes No

Subscriber Name _____ Subscriber Date of Birth _____

Auto Insurance _____ Public Assistance _____ Medicare _____ Personal Cash Payment _____

Private Insurance: Premera/Blue Cross _____ PHCO _____ Asuris _____ UHC _____ Cigna _____

Other _____ **PLEASE PROVIDE INSURANCE CARD TO BE COPIED.**

I understand and agree that health and accident insurance policies are an arrangement between the insurance carrier and myself. Furthermore, I understand that *DAY CHIROPRACTIC CLINIC, P.S.* will prepare any necessary report and forms to assist me in making collection from the insurance company. I authorize the release of any medical or other information necessary to process my claim(s). I also request payment of government benefits either to myself or to the party who accepts assignment and that any amount authorized to be paid directly to *DAY CHIROPRACTIC CLINIC, P.S.* This will be credited to my account upon receipt. *However*, I clearly understand that I am personally and fully responsible for all charges to my account. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered me will be immediately due and payable. I also agree that *DAY CHIROPRACTIC CLINIC P.S.* may impose reasonable interest, late charges, costs, and/or reasonable attorney's fees to me should my account become delinquent. I agree that any lawsuit for collection of my account may be brought in Spokane County, WA.

I have received or been advised of the Notice of Privacy Practices with Day Chiropractic Clinic, P.S.

Patient's Signature _____ Date _____

Parent or guardian signature authorizing care _____

DAY CHIROPRACTIC CLINIC, P.S.

Patient Name _____

PLEASE CHECK THE FOLLOWING CONDITIONS YOU HAVE HAD:

Cancer___ Diabetes___ Epilepsy___ Miscarriage___ Pleurisy___ Other_____

FAMILY HEALTH INFORMATION

Many health problems are the result of hereditary spinal weakness; thus, information about your family members will give us a better picture of your total health.

NAME	RELATIONSHIP	PAST OR PRESENT HEALTH PROBLEM
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_____	_____	_____
_____	_____	_____
_____	_____	_____

Medications presently on? _____

Are you now pregnant?_____ If yes, what is your expected date of delivery?_____

Have you ever had previous chiropractic care?_____ Who?_____

What is your major complaint?_____

How long have you had this condition?_____ Have you had it in the past?_____

Other complaints _____

Other doctors seen for this condition?_____

Is this condition aggravated by:

working___ walking___ exercise___ sitting___ lifting___ standing___ bending___
sneezing___ other_____

Is this condition getting progressively worse? Yes No Constant Comes and Goes

Is this condition interfering with your: (circle) work sleep daily routine walking other

List all surgical operations and in what years?_____
