Welcome To Advanced Spinal Care

Confidential Patient Information Sheet

Date: ____________________

Patient's Name: ________________________

Address: _____________________City: ______________ State: _____ Zip: _______

Date of Birth: ____/____/____ Age: ____ Social Security Number: ____-____-_____

Home Phone Number: (___) ___________ Work Phone Number: (___) ____________

E-mail address: _______________________________________

Marital Status: Married Single Divorced Widow(er)

Spouse: Name: _______________________________

Children:
1. Name _____________________________ Age: ________
2. Name _____________________________ Age: ________
3. Name _____________________________ Age: ________
4. Name _____________________________ Age: ________

Name of Employer: _____________________ Occupation: ___________________

Have You Been to A Previous Chiropractor? Yes or No

Name of Chiropractor _____________________ City: __________________

Name of Chiropractor _____________________ City: __________________

Do you prefer to pay by: ____Cash ____Check ____Credit Card

Do you have Health Insurance? Yes or No

If **YES**, please give your insurance card to the receptionist so that she may make a photocopy and confirm your level of coverage for spinal rehabilitation.

Payment Policies

1. **PAYMENT FOR YOUR FIRST DAY'S SERVICES IS DUE AT THE COMPLETION OF YOUR OFFICE VISIT.**
2. At the completion of your first visit, you will be advised as to the time you can return for your second consultation when the doctor will inform you of your examination results and whether or not your case has been accepted. You will be advised concerning recommendations, financial arrangements, and insurance coverage as appropriate.

Advanced Spinal Care

Name: ______________________________ Date: ____________________

1. What is the purpose of this appointment (major complaint – please circle)?
   Headache Low–Back Pain Neck-Pain Mid-Back Pain Arm Pain Leg Pain

   Other: ____

2. What is this condition due to (please circle)?
   Overexertion Strenuous Position Auto Accident Fall/Trip/Slip

   Other: ____

3. When did this problem first occur (please be specific)? ______________________

4. Is this condition getting better, staying the same, or getting worse? ________________

5. Has this condition been treated in the past? Yes or No

6. List other doctors who have treated this condition: ______________________

7. On a scale of 1 to 10 (10 bedridden pain / 0 = feeling fine) how bad does this condition make you feel?
   ____

8. How does the pain feel?
   Dull Ache Sharp & Stabbing Burning Throbbing

   Other: ____

9. Do you have pain, tingling, or numbness into either your arms or legs? ________________

10. Have you noticed an irregular bowl or bladder patterns? ______________________

11. What relieves your condition? ______________________________

12. What aggravates your condition? ______________________________

13. Does this condition interfere with your: Work Sleep Daily Routine

    Other: ____

14. What type of service do you desire? (please circle appropriate response)

    Temporary Relief Permanent Correction (if possible) Maintenance Care

15. List any serious illnesses: ______________________________

16. Are you pregnant? Yes or No

17. List any surgical operations and dates:

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ADVANCED SPINAL CARE

ASSIGNMENT & RELEASE

1. I authorize the release of information to my family physician and employer.
2. I authorize the release of information to insurance companies.
3. I authorize the performance of photographs and x-rays to be used for treatment purposes.
4. I authorize the performance of other diagnostic and therapeutic procedures and treatment.
5. I authorize my insurance benefits to be paid directly to:

ADVANCED SPINAL CARE
1300 SAVANNAH HWY. SUITE #6
CHARLESTON, SC 29407
(843) 573-9333

OR

ADVANCED SPINAL CARE
2134 DORCHESTER RD.
NORTH CHARLESTON, SC 29405
(843) 554-6056

I ACKNOWLEDGE THAT I AM FINANCIALLY RESPONSIBLE FOR NON-COVERED SERVICES. I ALSO UNDERSTAND THAT IF I TERMINATE MY CARE AND TREATMENT, ANY FEES FOR PROFESSIONAL SERVICES RENDERED TO ME WILL BE ***IMMEDIATELY DUE AND PAYABLE***.

Patient/Guardian: ____________________________ Date: __________