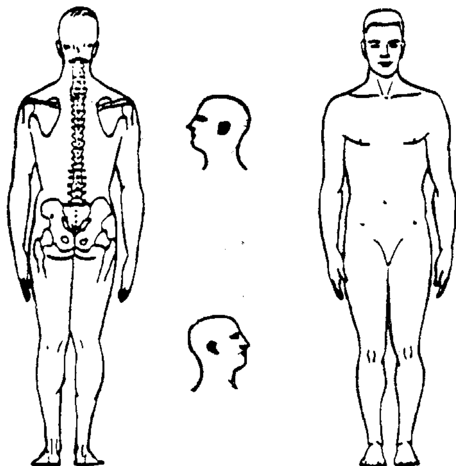
ARCADIA CHIROPRACTIC CLINIC, INC.

936 North Mills Avenue, Arcadia, FL 34266
(863) 494-7110 (863) 494-7555

PERSONAL INFORMATION

Name:____ Today's Date:_________________
Address:____ Birthdate:______________________
City:_____________________State:__________Zip:__________ Age:__________
Home Phone:__________________ Work Phone:____________________ Cell Phone:______________
Email:__________________________________ Social Security #___________________________
Occupation:______________________________ Employer:_________________________________
Marital Status: __ Married __Single __Widowed __Divorced __Separated
Name of Spouse: _________________ Spouse's Employer______________Spouse's Birthdate:_________
Whom shall we thank for referring you?____

CURRENT COMPLAINTS



Please describe the conditions you are currently experiencing. List in order of importance:

1.______________________________________
2.______________________________________
3.______________________________________
4.______________________________________
5.______________________________________

What functions are you **unable to perform**, or **induce pain** upon performance? (Example: sitting, walking, bending, lying down, etc.)

1.______________________________________
2.______________________________________
3.______________________________________
4.______________________________________
5.______________________________________

When was the very first time you became aware of this problem?:______________________________
____

Describe any accidents, falls, etc that may have caused your problem:__________________________
____

Please list most recent automobile accidents: __Past Year __Past 5 years __Over 5 years __Never

List names of other doctors you have seen for this problem:____________________________________
____

List the treatment received, and any radiographic studies performed (MRI's, xrays, CT scans, etc.):
____

Have you had same or similar symptoms or injuries before: __Yes __No If yes, please explain: ____
____

Have these problems been: __Getting better __Getting worse __Staying the same

GENERAL HEALTH HISTORY

Have you been treated for any health condition by a physician in the last year: __Yes __No
If yes, please explain:____
____
Have you previously received Chiropractic Treatment: __Yes __No
If yes, list physician consulted and for what problems: ____________________________________
____
Are you currently pregnant: __Yes __No
Please list any medications you are now taking: ____
____
List the any operations, unusual diseases, serious illness or accidents you have had along with approximate dates (include broken bones): ____
____

FINANCIAL RESPONSIBILITY

Who is responsible for your bill?: __Self __Employer __Insurance __Other____________________
Type of insurance: __Worker's Compensation __Automobile Insurance __Health Insurance
If **you** are responsible for fees, please list method of payment: __Cash __Check __Credit Card

Fees are payable at the time X-rays, examinations, and treatments are received, unless other arrangements have been made in advance. X-rays remain the property of this clinic. Arcadia Chiropractic Clinic physicians may use specific Chiropractic Manipulations and therapies in your treatment protocol. In addition, the Doctors may recommend treatment to include an Erchonia 635 nm laser or the EB-Pro Detox system. *I hereby give permission for treatment.*

Patient/Guardian signature ____ Date______________

If we will be filing to your insurance:

I authorize the release of any medical information necessary to process this claim. I also request payment of Government Benefits either to myself or to the party who accepts assignment.

I authorize payment of medical benefits to undersigned physician or supplier for service rendered. I have read and understand the above statement.

Patient/Guardian signature ____ Date ______________

Please provide front desk with a copy of the insurance card you wish to file

REQUEST FOR RELEASE OF MEDICAL RECORDS

To:____(Physician or Facility)
I hereby request that my medical records be released to **Arcadia Chiropractic Clinic, Inc.**, **936 N. Mills Ave., Arcadia, FL 34266, (863) 494-7110, FAX (863) 494-7555**

Patient/Guardian signature _______________________________________ Date _______________
Please Print Name ________________________________ Date of Birth __________________