



APPLICATION FOR TREATMENT

Please check type of care desired: Temporary Relief _____ Lasting Correction _____ Date _____

Title: Mr Mrs Ms Dr _____ Name _____

Address _____ Date of Birth ____/____/____

City _____ State _____ ZIP _____

Home Phone _____ Work Phone _____ Cell Phone _____

S.S.N. _____ - _____ - _____ Marital Status: S M Other _____ E-Mail _____

Name of Spouse _____

Who referred you to our office: _____

Your employer _____ Occupation _____

Address _____ City _____ ZIP _____

Describe the condition or reason for this visit: _____

Date of illness or injury: _____

How did it occur? Auto Accident _____ Work Accident _____ Fall _____ Other _____

Please describe: _____

Do you have an attorney that has advised you in this case? If yes, please list name and phone #: _____

Have you received any treatment for this condition? If yes, please list doctor and phone #: _____

Have you had this problem before? Please explain: _____

How has this condition affected your life:

- A. Home Life _____
B. Occupational Life _____
C. Recreational Life _____
D. Rest and Sleeping Life _____

Drugs/Supplements you are taking (including over the counter) _____

Are you pregnant? Yes No

PAYMENT EXPECTED AT TIME OF VISIT

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and me. I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. 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. Unless a 12 hour notice is given there could be a charge for missed appointments.

If you are under the age of 18 Parental Consent is required for treatment.

Patient's signature _____ Date _____

Parent or Legal Guardian's signature _____ Date _____

Because We Care