NEW PATIENT FORM

HOLLAND CHIROPRACTIC CENTER
A ChiroFlex Company

Today's Date: _____

Patient Information

Name: _____ Date of Birth: _____

Address: _____

Best Contact Phone: _____ Email:_____

Employment Information

Name of Employer: _____ Phone: _____

Title/Position: _____

Medical History

Reason for Visit: _____

Have you been to a Chiropractor before? Yes or No- If so, How long ago? _____

Medications

Please list any medications or supplements you are taking and the condition for which you are taking them:

_____

_____

_____

_____

WOMEN ONLY: Are you pregnant? _____ Are you nursing? _____

Visual Analogue Scale Please circle the number that best describes the question being asked.
If you would like to mark for more than one time of pain for each question, please label the additional circles. For example, you may use "N" for neck, "LB" for low back, and "H" for headaches.

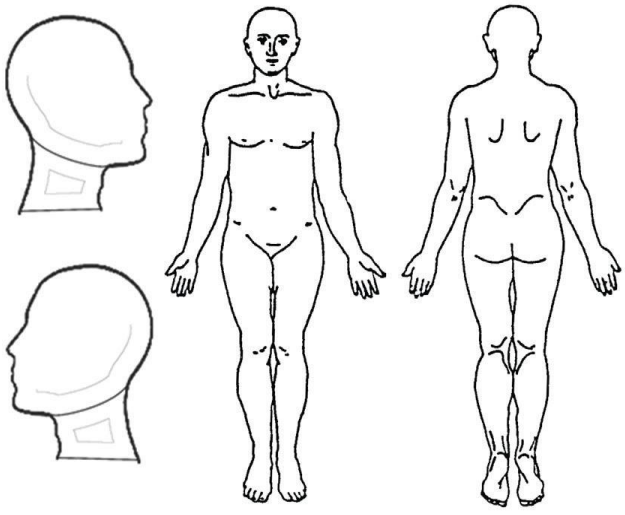
What is your pain right now?

Pain Free **Worst Pain Possible**

_____

0 1 2 3 4 5 6 7 8 9 10

Please map where your pain/symptoms are located



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Any Idea what Caused this Pain/Problem?

_____

_____

When did this pain/problem start?

_____

How would you describe the pain/discomfort? (Circle all that apply)

ACHE SHARP DULL THROBBING TIGHT NUMB SHOOTING BURNING

What relieves your pain/discomfort?

STRETCHING REST CHIROPRACTIC SITTING EXERCISE MEDICATION HEAT ICE NOTHING

What aggravates your pain/discomfort?

DRIVING - HOUSEWORK - LIFTING - SITTING TO STANDING - STANDING TO SITTING LAYING DOWN - TWISTING - BREATHING DEEP - LITERALLY DOING NOTHING

Other:_____

Patient Signature: _____ Date: _____

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Welcome to our Office!

Chiropractic makes no claim to cure conditions but to adjust the subluxation (misalignment of the spine) thus restoring better nerve supply for the restoration of health, naturally. Additionally, any nutritional supplementation supplied is solely to enhance the patient's general overall health through proper nutrition and not to treat or cure any specific condition or disease. Our office policy requires payment in full for all services rendered at the time of visit, unless other arrangements have been made with the office. Our office participates with most insurances, and for those patients who are covered by insurance, our office will bill the services. Upon completion of all insurance billing, the patient will be responsible for any deductibles, co-payments or any services denied by the insurance company. If the account is not paid in full or no payments received by the patient within 90 days after services have been performed, this office will take steps to collect through a professional collection agency.

I agree to be financially responsible for all charges incurred at this office including all debt denied by my insurance provider.

Signature of Patient: _____ Date: _____

Witness (office staff): _____ Date: _____

AUTHORIZATION TO RELEASE INFORMATION REGARDING BILLING, MEDICAL APPOINTMENT, OR OTHER HEALTHCARE/MEDICAL INFORMATION

The following individual(s) are authorized to receive this information:

_____ Relationship: _____

_____ Relationship: _____

Signature of Patient: _____ Date: _____

HOLLAND CHIROPRACTIC "PRIVACY PRACTICES"

I acknowledge that Holland Chiropractic Center (A Chiro Flex Company) provided me with a Notice of Privacy Practices. I understand I have a right to review the Privacy Practices prior to signing this document. The notice of Privacy Practices describes the types of use and disclosures of my protected health information that will occur in my treatment, payment of bills, or in the performance of healthcare operations of the Holland Chiropractic Center. Holland Chiropractic Center reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised notice of privacy practices by calling the office and requesting a revised copy to be sent via mail or at the next office visit.

Signature of Patient or Personal Representative _____ Date: _____

(Print) Name of Patient or Personal Representative _____ Date: _____

Description of Personal Representative's Authority_____ Date: _____