one

WELCOME

ABOUT YOU

Today's Date: ___/___/___ DL #: ___

Patient Name: ___ LAST ___ FIRST ___ MI

What You Prefer To Be Called: ___ ❑ Male ❑ Female

Birthdate: ___/___/___ Age: ___ SS#: ___

Mailing Address: ___

___ CITY ___ STATE ___ ZIP

Home Phone #: ___

Work Phone #: ___ Ext: ___

Other Phone #s: ___

E-Mail Address: ___

___

Employer: ___ How Long? ___

Employer's Address: ___

___ CITY ___ STATE ___ ZIP

Occupation: ___

Status: ❑ Minor ❑ Single ❑ Married ❑ Divorced ❑ Separated ❑ Widowed

Spouse's Name: ___

Do you have children? ❑ Yes ❑ No How many? ___

two

INSURANCE INFO

Co. Name: ___

Address: ___

___ CITY ___ STATE ___ ZIP

Phone #: ___

Insured's ID #: ___

Group # (Plan, Local, or Policy #): ___

Insured's Name: ___

Relation: ___ Date of Birth: ___/___/___

Insured's Employer: ___

Please inform front desk of 2nd. Insurance source.

REASON FOR VISIT

The reason for this visit is a result of (*Please circle*): work, sports, auto, trauma or chronic.

(*Explain what happened*): ___

___

Please describe the pain & its location: ___

___

When did condition begin? ___/___/___

Is this condition getting worse? ❑ Yes ❑ No ❑ Constant ❑ Comes and goes

Is this condition interfering with your (*Please Circle*): work, sleep, or daily routine.

If so, please explain: ___

Have you had this or similar conditions in the past? ❑ Yes ❑ No

If so, please explain: ___

Have you been treated by a Medical Physician for this condition? ❑ Yes ❑ No

If so, where? ___

Have you ever been treated by a Chiropractor before? ❑ Yes ❑ No

If so, whom? ___ Phone#: ___

three

PLEASE CONTINUE ON BACK

4 four

IN EVENT OF EMERGENCY

Who should we contact? ______________________

Relation: ______________________

Home Phone #: ______________ Work Phone #: ______________

Who is your Medical Doctor? ______________ Phone #: ______________

HEALTH HISTORY

Are you taking any of the following medications?

❏ Nerve pills ❏ Pain killers (including aspirin) ❏ Muscle relaxers ❏ Stimulants
❏ Blood Thinners ❏ Tranquilizers ❏ Insulin ❏ Other(s) ______________

Do you have or ever had any of the following diseases or conditions?

Y N Heart Attack / Stroke	**Y N** Heart Surg./Pacemaker	**Y N** Heart Murmur
Y N Congenital Heart Defect	**Y N** Mitral Valve Prolapse	**Y N** Artificial Valves
Y N Alcohol / Drug Abuse	**Y N** Venereal Disease	**Y N** Hepatitis
Y N HIV+ / Aids	**Y N** Shingles	**Y N** Cancer
Y N Frequent Neck Pain	**Y N** Emphysema / Glaucoma	**Y N** Anemia
Y N High/Low Blood Pressure	**Y N** Psychiatric Problems	**Y N** Rheumatic Fever
Y N Severe/Frequent Headaches	**Y N** Kidney Problems	**Y N** Ulcers / Colitis
Y N Fainting/Seizures/Epilepsy	**Y N** Sinus Problems	**Y N** Asthma
Y N Diabetes / Tuberculosis	**Y N** Difficulty Breathing	**Y N** Chemotherapy
Y N Lower Back Problems	**Y N** Artificial Bones / Joints	**Y N** Arthritis

Please list any other serious medical condition(s) you have or ever had:

____

Please list anything that you may be allergic to: ______________________

____

List previous surgeries/treatments with dates: ______________________

____

List any **past** serious accidents with dates: ______________________

____

Family Health History: ______________________

____

Do you: Take Supplements or Vitamins? ❏Yes ❏ No / Exercise? ❏Yes ❏ No

Are you on a special diet: ❏ Yes ❏ No / Since: ____/____/____

Do you smoke? ❏ No ❏ Yes / How Much? ________ How Long? ________

Are you wearing: ❏ Heel Lifts ❏ Sole lifts ❏ Inner soles ❏ Arch supports

What is the age of your mattress? _____ Is it comfortable? ❏ Yes ❏ No

For women: Are you taking Birth Control? ❏ Yes ❏ No

Are you Pregnant? ❏ No ❏ Yes/How long? _____ Nursing? ❏ Yes ❏ No

5 five

6 six

ACCOUNT INFO

Person ultimately responsible for account

Name: ______________________

Relation: ______________________

Billing Address: ______________________

____
CITY STATE ZIP

SSN: ______________________

D.L.#: ______________________

Work Phone#: ______________________

Payment method: ❏ CASH ❏ Check

______________________ ___/___

❏ Credit Card - ~~Enter card # above (if accepted)~~

_______ Initials I hereby authorize assignment of my insurance rights and benefits directly to the provider for services rendered. I fully understand I am solely responsible for any balance not paid by my insurance company (if offered at this office).

- We invite you to discuss with us any questions regarding our services. The best health services are based on a friendly, mutual understanding between provider and patient.
- Our policy requires payment in full for all services rendered at the time of visit, unless other arrangements have been made with the business manager. If account is not paid within 90 days of the date of service and no financial arrangements have been made, you will be responsible for legal fees, collection agency fees, and any other expenses incurred in collecting your account.
- I authorize the staff to perform any necessary services needed during diagnosis and treatment. I also authorize the provider and or managed care organization, to release any information required to process insurance claims.
- I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes to the information I have provided.

Signature ______________________ Date ___/___/___
❏ Adult Patient ❏ Parent or Guardian ❏ Spouse

PLEASE RECYCLE SO THAT WE MAY PRESERVE THE HEALTH OF OUR PLANET.

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Genesis Chiropractic

Dr. Samuel T. Laffel

2922 Oak Lawn Avenue
Dallas, TX 75219
(214) 219-4325
(214) 526-2267- *fax*

CONSENT TO TREAT

I hereby give consent to Dr. Samuel T. Laffel and Genesis Chiropractic to provide Chiropractic care to myself and/or family. I understand there is a fee for services and understand that the fee is payable at the time services are rendered. I hereby agree to such fees and understand that I am liable for any and all legal fees if collection services are necessary.

Signature:______________________________**Date**__________

Witness:______________________________**Date**__________

Release and Assignment

I authorize the release of any medical or other information necessary to process claims. I also assign my benefits and request payment of MPC, Medical, Chiropractic, or 3rd party benfits for services to be paid directly to **Dr. Samuel T. Laffel** or **Genesis Chiropractic** for services rendered. This assignment is irrevocable until all debts on this account have been paid in full.

Signature of insured:__________________________

Date Signed:________________________________

"Healing the World, One spine at a time"
Samuel T. Laffel, D.C.

Genesis Chiropractic

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CONSENT FOR X-RAYS

I, ________________________________ do hereby give my consent to **Genesis Chiropractic** and its representative, to take X-Rays as deemed appropriate by the examining doctor of chiropractic. I also hereby declare, to the best of my knowledge, that I am not pregnant.

____

PATIENT'S SIGNATURE DATE

____

DATE OF LAST MENSTRUAL CYCLE (WOMEN)

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