Welcome to Dudley Chiropractic

Patient ______________________________ Date ____________________

Address ______________________________ City ____________________

State __________ Zip ____________ Referred By ____________________

Home (____)____________ Cell (____)____________ Wk (____)____________

Email ____________________ Birth date ________________ Age __________

SS# ____________________ Marital Status ____________ Are you? *Male* *Female*

Employer ____________________ Address ______________________________

Spouses Name ______________________________ Birth date ________________

SS# ________________ Phone (____)____________ Employer ________________

Emergency Contact ______________________________ Phone (____)____________

Insurance Information

Insurance Co. ______________________________ Id # ____________________

Insured's Name ____________________ Relationship to patient ________________

Insured's Address ____

Insured's Birth date ________________ Insured's employer ________________

Emp. Address ____

Emp. Phone (____)________________ Insured's Phone (____)________________

Is visit related to an accident? *YES* *NO* Type of accident? *WORK* *AUTO* *HOME*

Date of Accident ____________________ Claim # ____________________

Consent to treat/ X-ray release

Consent to treat minor Child: I hereby authorize this office to administer chiropractic care as deemed necessary for my child.

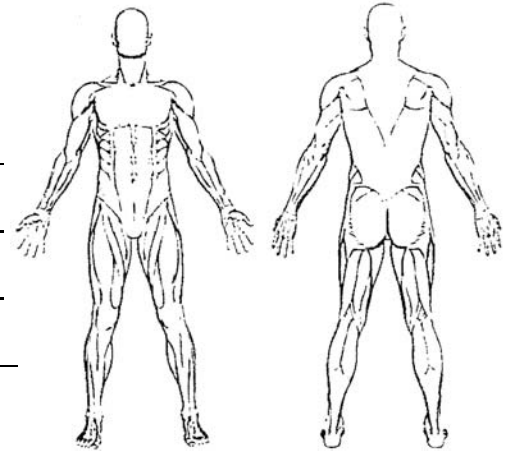
Signature of parent/ legal guardian: ______________________________ Date ____________________

X-ray Confirmation: This certifies that concerns regarding pregnancy and radiation have been explained to my satisfaction. I understand the clinical necessity for having x-rays taken at this time and grant my permission for this procedure. In doing so, I release the Doctor from responsibility of potential damage arising form this procedure.

Signature: ____ Date ____________________

Patient Condition ˜ Name________________

Mark an (X) in the areas of the of the picture to the right where you are having symptoms



Please list your main complaint in order of severity

1.________________________________How long?__________

2.________________________________How long?__________

3.________________________________How long?__________

What motivated you to seek help now? ______________________________

What treatments have you received for your condition? (please circle all that apply)

Medications Surgery Physical therapy Chiropractic Massage None Other ____________

Is this your first visit to a chiropractor? YES NO

Health History

Please list any Doctors consulted for current condition(s)
Dr.______________________________ Address______________________________

Have you had recent x-rays? YES NO When ______________ Where______________

Please check mark box "c" for current or "p" for past to indicate if you have had any of the following:

JTTVF!	C	P	ISSUE	C	P	ISSUE	C	P	ISSUE	C	P
Allergies			Dizziness			Jaw Problems			Nervousness		
Arthritis			Fatigue			Kidney Disease			Numbness		
Asthma			Fainting			Loss of Balance			Pins & needles in leg		
Back Pain			Fever			Loss of smell/taste			Ringing in ears		
Bronchitis			Fractures			Light sensitivity			Seizures		
Buzzing in Ears			Fertility prob.			Migraine			Shoulder Pain		
Cancer			Headache			Miscarriage			Sinus issues		
Constipation			Herniated disk			Menstrual Irregularity			Sleep issues		
Curvature of spine			Hernia			Menstrual pain			Stomach upset		
Depression			High blood pressure			Mood swings			Stroke		
Diabetes			Hot flashes			Neck Pain			Thyroid issues		
Digestive issues			Irritability			Neck Stiffness			Ulcers		

List any medications you are currently taking______________________________

Are you Pregnant? YES NO Due date______________ Number of previous Births ______________

Have you ever?
Broken Bones YES NO When______________ Explain ______________
Been Hospitilized YES NO When______________ Explain ______________
Had an auto accident YES NO When______________ Explain ______________
Had a head injury YES NO When______________ Explain ______________

What are your expectations of us? ______________________________

Dudley Chiropractic Financial Agreement

Dear Patient:
Dudley Chiropractic will work with you to provide the necessary information to determine the type of care you require and also the financial information you may need to determine how you wish to handle your financial obligation to Dudley Chiropractic.

We wish to make it very clear that your health is your sole responsibility.

These policies apply only to the services actually preformed, and in no way obligates the patient to continue the course of care recommended. If care is discontinued, the balance due for care received up to that date is due in full within 30 days of discontinuance of care.

I choose the following method of payment for my care at Dudley Chiropractic:

_____ **CASH** - Payment is due at the time of services.

_____ **MEDICARE -** Payment is due at time of service. Dudley Chiropractic will bill Medicare if requested. Dudley Chiropractic is not a Medicare Preferred Provider and does not accept assignment from Medicare.

_____ **INSURANCE POLICY COVERAGE** - Although I am totally responsible for charges I may incur at Dudley Chiropractic, I will initially pay for my yearly deductible and the percentage agreed upon at the time of each visit unless my insurance fails to pay it's share, at which time I will pay my balance in full.

I certify I have insurance with ____ and assign directly to Dr. Timothy Dudley all insurance benefits otherwise payable to me for services rendered. I understand I am personally financially responsible for all services rendered by Dudley Chiropractic whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

Dr. Dudley may use my health information and may release such information to any insurance company, adjustor or attorney and their agents for the purpose of obtaining payment for services rendered by Dudley Chiropractic, and I hereby release Dr. Dudley of any consequence thereof.

NOTE : Dudley Chiropractic will refund or apply to future services any over payments made by patient at patients option, upon patients request.

My signature below also certifies I have received a copy of Dudley Chiropractic's HIPPA Privacy Practices and accept its terms.

PATIENTS NAME: (please print)____

SIGNED: __________________________________this ________day of_____________20____.

<u>TERMS OF ACCEPTANCE</u>

When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for both to be working towards the same objective.

Chiropractic has only one goal. It is important that each patient understand both the objective and the method that will be able to attain it. This will prevent any confusion or disappointment.

Adjustment: An adjustment is the specific application of forces to facilitate the body's correction of vertebral subluxation. Our chiropractic method of correction is by specific adjustments of the spine.

Health: A state of optimal physical, mental, and social well-being, not merely the absence of disease or infirmity.

Vertebral Subluxation: A misalignment of one or more of the 24 vertebra in the spinal column which causes alteration of nerve function and interference to the transmission of mental impulses, resulting in a lessening of the body's innate ability to express its maximum health potential.

We do not offer to diagnose or treat any disease or condition other than vertebral subluxation. However, if during the course of a chiropractic spinal evaluation, we encounter non-chiropractic or unusual findings, we will advise you. If you desire advice, diagnosis or treatment for those findings, we will recommend that you seek the services of a health care provider who specializes in that area.

Regardless of what the disease is called, we do not offer to treat it. Nor do we offer advice regarding treatment prescribed by others. **OUR ONLY PRACTICE OBJECTIVE** is to eliminate a major interference to the expression of the body's innate wisdom. Our only method is specific adjusting to correct vertebral subluxations.

I, ____________________________ have read and fully understand the above statements.

(print name)

All questions regarding the doctor's objectives pertaining to my care in this office have been answered to my complete satisfaction.

I therefore accept chiropractic care on this basis.

____

____

(signature)

(date)