Medical History Information

Last Name: First Name:		Middle:		Birthdate: Single /Married/ Divorced Separated/ Widow	
Email:				Age:	Sex:
Address:		City:		State:	
ZIP Code:	Social Security No.:		Home Phone:		
Occupation:	Employer:			Employer phone:	

Medical Care Information

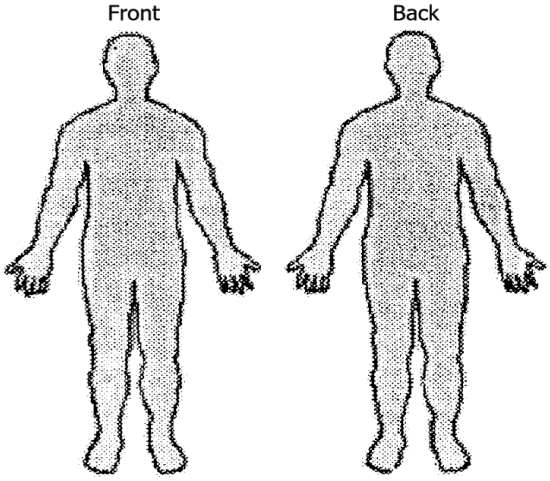
Do You Have a Family Doctor? ☐ No ☐ Yes, Name of Doctor:			
Address:	City:	State:	ZIP Code:
Date of last Visit: / /	Date of last exam: / /		
Have you been to a Chiropractor? ☐ No ☐ Yes, Name of Chiropractor:			
Date of last Visit: / /			
Have you had any surgeries in the last 5 Years: ☐ Yes ☐ No If yes, Last Surgery Date:			
Reason for Surgery:			

Present illness /Conditions:

☐ AIDS	☐ Cancer	☐ Heart Problem	☐ Multiple Sclerosis	☐ Spinal Disc Disease	
☐ Allergies	☐ Cirrhosis/hepatitis	☐ High blood pressure	☐ Pacemaker	☐ Thyroid trouble	☐ Epilepsy
☐ Anemia	☐ Diabetes	☐ HIV/ARC	☐ Prostate trouble	☐ Tuberculosis	☐ Pregnant
☐ Arthritis	☐ Dislocated joints	☐ Kidney trouble	☐ Rheumatic fever	☐ Ulcer	☐
☐ Asthma	☐ Diverticulitis	☐ Low Blood Pressure	☐ Scoliosis	☐ Polio	☐
☐ Bone fracture	☐ Hay Fever	☐ Mental/ Emotional Difficulty	☐ Sinus trouble	☐ STD'S	☐

Other:

Please mark on the picture where you have had symptoms according to the indicated codes.
S = Stiffness A = Aching P = Pain N = Numbness T = Tingling B = Burning



TERMS OF ACCEPTANCE

We do not offer to diagnose or treat any disease. We only offer to diagnose either vertebral subluxations or neuro-musculoskeletal conditions. However, if during the course of a chiropractic spinal examination, 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 another health care provider.

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 subluxation. However, we may use other procedures to help your body hold the adjustments.

I therefore accept chiropractic care on this basis.

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. I clearly understand and agree that I am personally responsible for payment of all services, which are rendered to me that my insurance company does not pay. Some insurance companies have a limited number of visits allowed per calendar year. I understand that if I go over the number of allowed visits, I will be responsible for the cost of the visits. I also understand that if I suspend or terminate my care and my treatment, any fees for professional services, which are rendered to me, will be immediately due and payable. You may authorize us to keep your credit card on file for your convenience. A $25.00 service fee will be charged for all returned checks. Should my account become delinquent, I will be responsible for interest, rebilling charges, or collection fees, including but not necessarily limited to attorney fees and court costs incurred in collection attempts on my account. I hereby authorized Betterton Family Chiropractic to release any information to my insurance company/attorney acquired in the course of my examination or care. I also authorize insurance payment to be made to Betterton Family Chiropractic. I understand that a photocopy of the above assignment and authorization will be deemed as valid as the original.

Appointment Reminders and Health Care Information Authorization: At times our office may need to contact you with appointment reminders, missed appointments or information about treatment or other health related information. By signing below, you are giving us authorization to contact you with these reminders/information and understand that I may be contacted by: phone at home or work, mobile phone, e-mail, or postcard or Email and messages may be left.

Appointment Reminders Preferences: □ I would like to receive appointment reminders via automated email.
Preferred Email Address: _____
□ I would like to receive appointment reminders via automated text message. Phone #:_____-_____-_____
Phone Service Provider: _____
□ I would prefer not to receive any appointment reminders from this office.

HIPAA Notice: I understand and agree to allow this chiropractic office to use their Patient Health Information for the purpose of treatment, payment, healthcare operation, and coordination of care. We want you to know how your Patient Health Information is going to be used in this office and your rights concerning those records. If you would like a more detailed account of your policy and procedures concerning the privacy of your Patient Health Information, we encourage you to read the HIPAA Notice that is available for you at the front desk before signing this consent. If there is anyone you do not want to receive your medical records please inform our office.

Informed Consent for Chiropractic Treatment: I hereby request and consent to the performance of chiropractic adjustments, other chiropractic procedures, and diagnostic x-rays, on me (or of said minor) by Betterton Family Chiropractic and/or its employees. I understand and am informed that, as in the practice of medicine, in the practice of chiropractic there are some risks to treatment, including but not limited to fractures, disc injuries, stroke, dislocations and sprains. Patients must inform the practitioner of any possibility of pregnancy at any point during the treatment process. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely upon the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known to him/her, is in my best interest. I understand that results are not guaranteed. I have read, or had read to me, the above consent. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above-named procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

Patient's Signature: (parent if minor) _____ Date: _____

Parent printed name (if minor) _____ Relationship_____

Parent Date of birth_____