AGLA
Chiropractic
Ease for all ages & stages of life!

Claim#: _____
P.O. Box 23955, Federal Way, WA 98093
Phone: (253) 632-5320 Fax: (253) 214-7444
www.AGLAchiro.com

PATIENT UPDATE INFORMATION

Patient Name:_____ Today's Date:_____

□ Change of Address, Employment or Contact Information:

New Street Address:_____
City:_____ State:_____ Zip:_____
Home Ph#:_____ Cell Ph#:_____Work Ph#:_____

E-Mail Address:_____ Website:_____

Employer:_____
City:_____ State:_____ Zip:_____

□ Change of Insurance Information:

□ **New Primary Insurance Information:** □ **New Secondary Insurance Information:**

Name of Insurance Company:_____ Phone Number:_____
Policy / Subscriber ID #:_____ Group #:_____
Subscriber's Relationship to Patient: □ Self □ Spouse □ Parent □ Other_____
Subscriber's Full Legal Name:_____ _____ _____
Last Name *First Name* *M.Initial*
Subscriber's Date of Birth:_____ Phone Number:_____
Subscriber's Street Address:_____
City:_____ State:_____ Zip:_____
Subscriber's Employer:_____
City:_____ State:_____ Zip:_____

□ Change of Name or Marital Status:

Marital Status: □ Single □ Married □ Divorced □ Widowed
Full Legal Name:_____ _____ _____
Last Name *First Name* *M.Initial*
New Driver's License#:_____ State:_____

Spouse's Name:_____ _____ _____
Last Name *First Name* *M.Initial*

□ NO Change of Personal Information: **PATIENT'SINITIALS:_____**

FINANCIAL AGREEMENT/ASSIGNMENT OF BENEFITS

I hereby give permanent authorization for payment of any and all insurance benefits to be made out directly to AGLA Chiropractic for services rendered here. If the current insurance policy prohibits direct payment to the doctor, then I hereby also instruct and direct the insurance company to make the check out to myself and AGLA Chiropractic, and mail it to the clinic directly. I understand that I am financially responsible for all charges whether or not they are covered by insurance. In the event of default, I agree to pay all costs of collections, and reasonable attorney's fees. I understand that interest will be charged at a rate of 1% per month, (12% per year), on the unpaid balance over 30 days old with a minimum charge of $ 0.50. I also understand that monthly payments are required of 20% or $25.00, whichever is greater. I hereby authorize Dr. Buclaw and Staff to release all information necessary to secure the payment of benefits. I further agree that a photocopy of this agreement shall be as valid as the original.

Date:_____ Signature:_____

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PRESENT SYMPTOMS OR COMPLAINTS

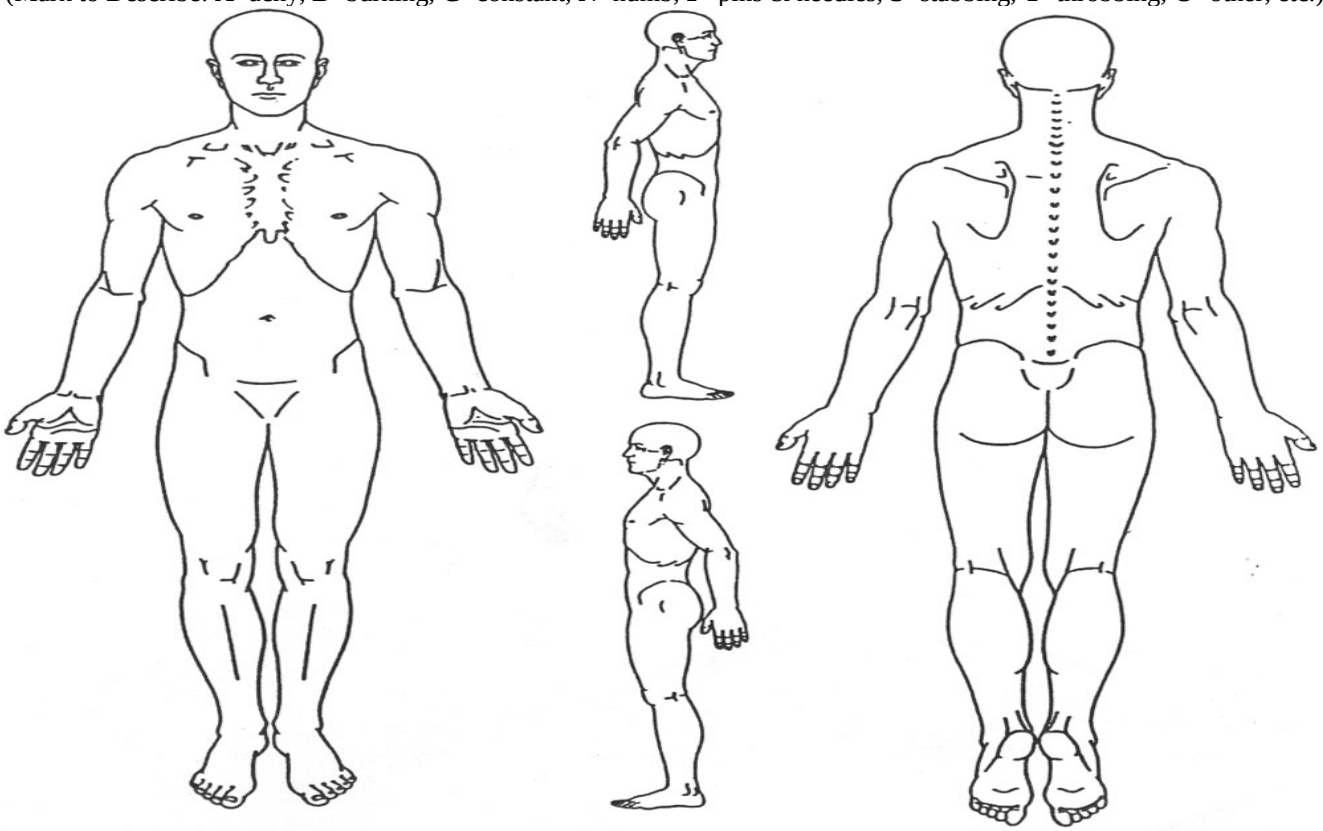
Patient Name:_____ Today's Date:_____
Where does it hurt?_____
How & When did it happen?_____
Describe the pain, (i.e., sharp, dull, grinding, pressure, throbbing, burning, etc):_____
Are there any radiations into the head, arms/hands, &/or legs/feet? Describe:_____
How frequent is the pain and when do you feel it?_____
What makes it: worse?_____ better?_____
List other Doctor/s seen for this condition:_____
Are you currently taking any medication? □ YES □ NO What kind?_____

What is your **maximum** pain/discomfort (without pain medications)? (**0** = No Pain **10** = Unbearable pain) **(Describe)**

Headache:	0	1	2	3	4	5	6	7	8	9	10 (_____)
Neck:	0	1	2	3	4	5	6	7	8	9	10 (_____)
Upper Back:	0	1	2	3	4	5	6	7	8	9	10 (_____)
Mid Back:	0	1	2	3	4	5	6	7	8	9	10 (_____)
Lower Back:	0	1	2	3	4	5	6	7	8	9	10 (_____)
Arm/Leg:	0	1	2	3	4	5	6	7	8	9	10 (_____)

CIRCLE THE AREAS OF DISCOMFORT

(Mark to Describe: **A**=achy, **B**=burning, **C**=constant, **N**=numb, **P**=pins & needles, **S**=stabbing, **T**=throbbing, **O**=other, etc.)



How much has your condition improved since your symptoms FIRST started?

-30% -20% -10% -5% **0%** 5% 10% 20% 30% 40% 50% 60% 70% 80% 90% 100%

PATIENT'S INITIALS:_____