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 INTRODUCTION FORM

How did you hear about our office (check any that apply)? □ Family/Friend Referred me:_____
□ Insurance Directory:_____ □ Internet Ad (Who?): _____ □ Print Ad in: _____
□ Drive-By □ Saw Sign/Window □ TV Commercial □ Heard Radio Ad □ Wellness Event at:_____
□ Screening Event at: _____ □ Other:_____

Patient's Personal Information: Sex: □ M □ F Date of Birth:_____

Full Legal Name:_____ _____ _____
Last Name *First Name* *M.Initial*

Street Address:_____
City:_____ State:_____ Zip:_____

Home/Cell Ph#:_____ E-Mail:_____ Last (4) of SS#(Required):_____

Employer:_____ Work Ph#:_____
City:_____ State:_____ Zip:_____

Marital Status: □ Single □ Married □ Divorced □ Widowed

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

Emergency Contact Information:
Name:_____ Relationship:_____
Home/Cell Ph#:_____ Work Ph#:_____ E-Mail:_____

PRIVACY PROTECTION

It is the policy of this office to protect the patient's privacy in accordance to state and federal regulations. Information regarding the patient and/or treatment will be shared only with other providers and insurance companies committed to protecting the patient's privacy and only for purposes of treatment, consultation, billing and collection of payment. Signature below indicates that the patient has read and understands the privacy protection policy and indicates consent to share their personal information as indicated and only when necessary.

APPOINTMENT CANCELLATION POLICY

Appointments that are not cancelled with at least 24-hours notice may be charged for the missed appointment. No call-No show appointments WILL BE charged $45.00 for the missed appointment(s) & loss of income for that scheduled time. Insurance companies will not be billed for these missed appointments.

I have read the above Privacy Protection & Appointment Policy.

Date:_____ Signature:_____

Witness:_____

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INSURANCE INFORMATION

Is your visit to our office today related to an auto accident or work related accident? □Yes □No

□ **Primary Insurance Info. (Self/Spouse,etc):** **Injury Claim#:**_____
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:_____

□ **Other Party's Insurance Info:** □ **Secondary Insurance Info:** **Injury Claim#:**_____
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:_____

FINANCIAL AGREEMENT/ASSIGNMENT OF BENEFITS

I understand that the initial evaluation/exam at AGLA Chiropractic costs no less than $52.00 at the time of service and agree to pay that sum whether or not I decide to continue with recommended treatment. 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.

Method of Payment: □Cash □Check □Credit/Debit Card (Visa/MC/Disc) □Health Ins. □Auto Ins. □Work Comp

Date:_____ Signature:_____

Witness:_____

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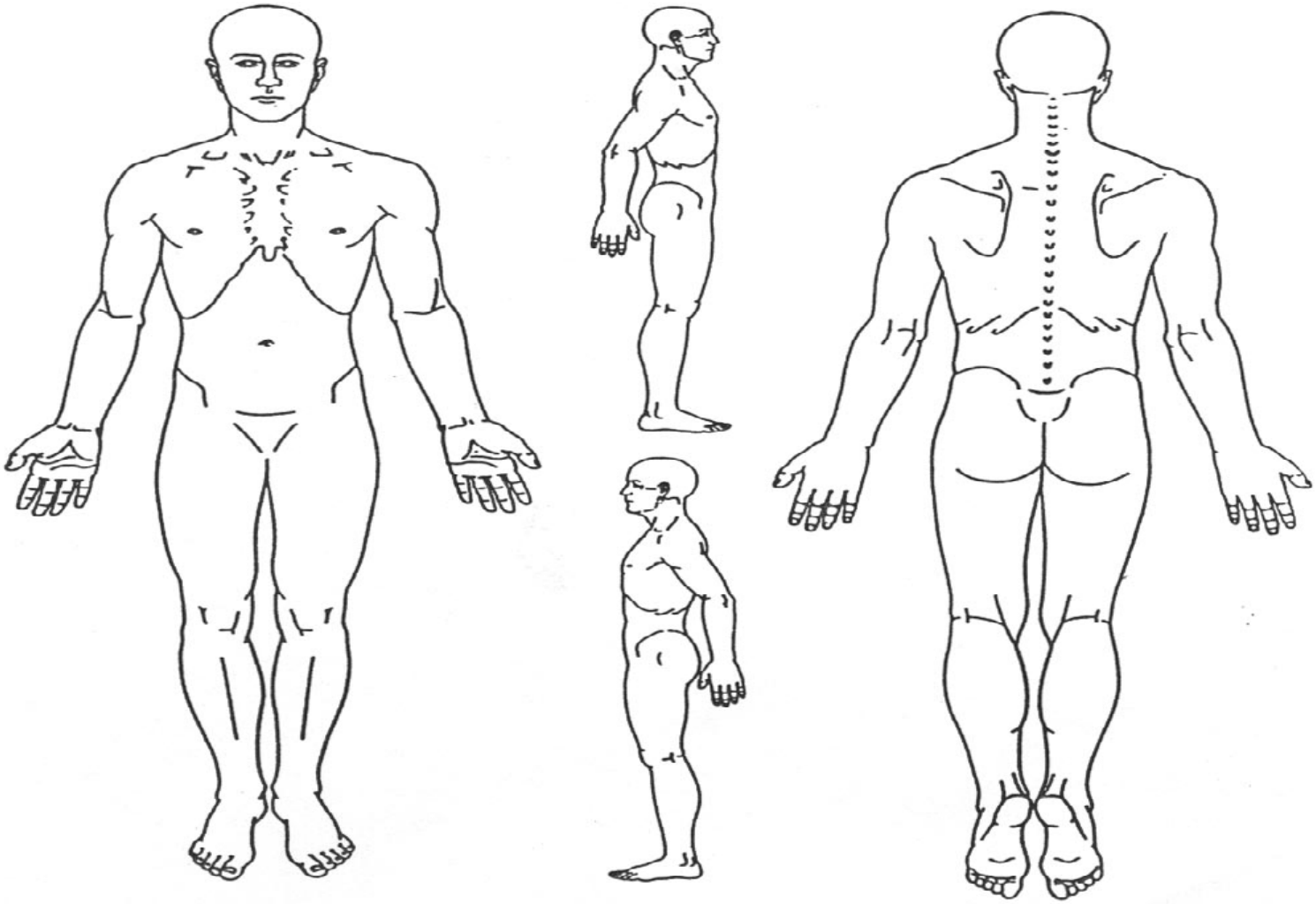
Patient Name:_____ Date:_____

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

											(Details)
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:_____

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Patient Name:_____ Date:_____
Is your condition a result of an Auto Accident? □ YES □ NO Is it due to a Work Injury? □ YES □ NO
PRIMARY CARE PHYSICIAN: Name/Clinic:_____
Street Address:_____ Ph#:_____
City:_____ State:_____ Zip:_____

PRESENT Symptoms or Complaints

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?_____
Are you allergic to any medication? □ YES □ NO
What kind?_____

IMPORTANT **Are you Pregnant, or is it possible you are?** □ **YES** □ **NO**

PRIOR Medical HISTORY (Check any and all that apply)

□ HEADACHES / MIGRAINES	□ DISC HERNIATION	□ ASTHMA	□ CONVULSIONS / EPILEPSY
□ NECK PAIN / STIFFNESS	□ NUMBNESS & TINGLING	□ COPD	□ DIZZINESS / FATIGUE
□ SHOULDER / ARM PAIN	□ NEURITIS	□ HEART TROUBLE	□ STRESS / ANXIETY
□ WRIST / HAND TROUBLE	□ ORTHOPEDIC PROBLEMS	□ HIGH BLOOD PRESSURE	□ NERVOUS DISORDER
□ CARPAL TUNNEL	□ FRACTURES	□ HIGH CHOLESTEROL	□ CHICKEN POX / SHINGLES
□ UPPER BACK PAIN	□ BURSITIS / TENDONITIS	□ POOR CIRCULATION	□ GERMAN MEASLES
□ MID BACK PAIN	□ RHEUMATISM	□ DIABETES	□ RHEUMATIC FEVER
□ LOW BACK PAIN	□ EYE PAIN	□ ANEMIA	□ TUBERCULOSIS
□ SCIATICA	□ BLURRY VISION	□ HEPATITIS	□ MUSCULAR DYSTROPHY
□ HIP / LEG PROBLEMS	□ EAR PAIN	□ ULCERS	□ MULTIPLE SCLEROSIS
□ ANKLE / FOOT TROUBLE	□ RINGING IN EARS	□ DIGESTIVE DISORDERS	□ FIBROMYALGIA
□ ARTHRITIS / JOINT PAIN	□ SINUS TROUBLE	□ DIARRHEA/CONSTIPATION	□ CANCER
□ SCOLIOSIS	□ ALLERGIES	□ CONCUSSION	□_____

Briefly Describe:_____
_____
Have you been treated by a physician for any of these health conditions in the last year? □ YES □ NO
If so, briefly describe treatment and results: _____
_____
List any hospitalizations, surgeries & dates:_____
_____
Describe any past traumas you have experienced & dates: (car accidents, sports injuries, big slips/trips/falls, head plants, etc.)
_____
_____
When was your last chiropractic treatment and what were the results?_____

PATIENT'S INITIALS:_____