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Date:___

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

Change of Address; Employment or Contact Information: New Street Address:	<u>PATIENT UPDA</u>	ATE INFORMATION	<u>\</u>						
Home Ph#: Cell Ph#: Website: E-Mail Address: Website: Employer: City: State: Zip: Change of Insurance Information: New Primary Insurance Information: Phone Number: Phone Number: Group #: Subscriber's Relationship to Patient: Subscriber's Pull Legal Name: First Name Mini Subscriber's Street Address: City: State: Zip: State: Zip: Subscriber's Employer: Street Address: Subscriber's Employer: State: Zip: State: Zip: State: Zip: Subscriber's Employer: State: State: Zip: State: Zip: State: Subscriber's Employer: State: State: Zip: State: Subscriber's Employer: State: State: State: Subscriber's Employer: State: State: State: State: Subscriber's Employer: State: State: State: Subscriber's Employer: State: State: State: Subscriber's Employer: State: State: Subscriber's Employer: State: State: Subscriber's Employer: State: State: Subscriber's Employer: State: Subscriber's Employer: State: Subscriber's Employer: Subscriber's Employer: Subscriber's Employer: Su	Patient Name:		Today's Date:						
City: State: Zip:	☐ Change of Address, Employment or Contact Inform	nation:							
City: Cell Ph#: Work Ph#: E-Mail Address: Website: Work Ph#: E-Mail Address: Website: Zip: Change of Insurance Information: New Secondary Insurance Information: New Primary Insurance Information: Phone Number: Group #: Subscriber S Relationship to Patient: Self Spouse Parent Other Subscriber's Full Legal Name:									
Home Ph#:	City:	State:	Ziţ);					
Employer: City: State: State: New Secondary Insurance Information: New Primary Insurance Information: Name of Insurance Company: Phone Number: Plone Number: Subscriber's Relationship to Patient: Subscriber's Full Legal Name: Last Name Phone Number: Subscriber's Street Address: City: State: City: State: State: Zip: City: State: Zip: Change of Name or Marital Status: Marital Status: Single Married Divorced Widowed First Name M.Ini Phone Number: State: State: State: State: Phone Number: State: State: State: State: State: Dip: Change of Name or Marital Status: New Driver's License#: Spouse's Name: Last Name Last Name First Name M.Ini 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 instruct and direct the insurance company to make the check out to myself and AGLA Chiropractic, and mail it to the clinic	Home Ph#: Cell Ph#:		Work Ph#:						
Employer: City:									
City: State: Zip: New Primary Insurance Information: New Primary Insurance Information: New Primary Insurance Company: Phone Number: Phone Number: Phone Number: Subscriber's Relationship to Patient: Self Spouse Parent Other Subscriber's Full Legal Name: Phone Number: Subscriber's Full Legal Name: Phone Number: Subscriber's Street Address: Phone Number: Subscriber's Employer: State: Zip: State: Zip: Subscriber's Employer: City: State: Zip: State: Zip: State: Zip: State: Zip: State: Zip: Subscriber's Employer: State: Zip: Stat	E-Mail Address:	Website:							
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Policy / Subscriber ID #: Group #: Grou	Name of Insurance Company:								
Subscriber's Relationship to Patient:	Policy / Subscriber ID #		Group #.						
Subscriber's Full Legal Name: Last Name First Name M.Ini	Subscriber's Relationship to Patient: Self Spouse	□ Parent □ Other	1						
Subscriber's Street Address: City: State: State: State: City: State: Spouse's Name: State: State: Spouse's Name: State: State: Spouse's Name: State: Spouse's Name Stat	Subscriber's Full Legal Name:			_					
Subscriber's Street Address: City: State: State: State: City: State: Spouse's Name: State: State: Spouse's Name: State: State: Spouse's Name: State: Spouse's Name Stat	<u>Last Name</u>		First Name	M.Initial					
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City: State: Zip: State: Zip: State: State: State: Sip: State: St	Subscriber's Street Address:								
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Change of Name or Marital Status: Marital Status: Single Married Divorced Widowed	Subscriber's Employer:								
Marital Status: □ Single □ Married □ Divorced □ Widowed Full Legal Name: Last Name First Name M.Ini	City:	State:	Ziŗ);					
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instruct and direct the insurance company to make the check out to myself and AGLA Chiropractic, and mail it to the clinic									
of default, I agree to pay all costs of collections, and reasonable attorney's fees. I understand that interest will be charged at									
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

Signature:_



Patient Name:

Claim#:	
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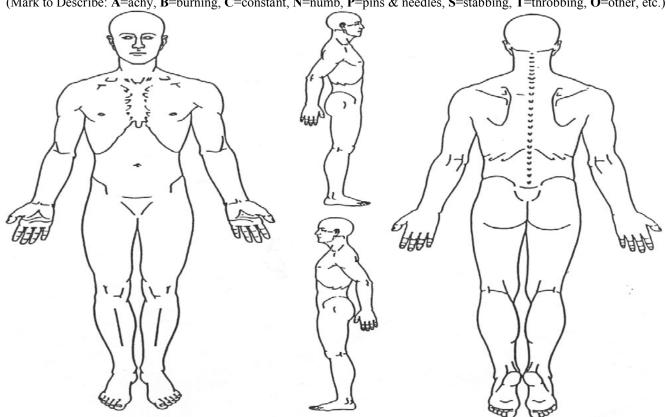
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Today's Date:____

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? \[\text{VES} \text{NO} \text{ What kind?} \]												
What is your <u>maximum</u> 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%