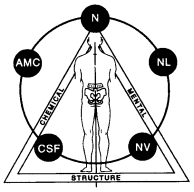

Holistic Health & Chiropractic of Frankfort
Jon K. Heyer, D.C.

Patient Registration and Case History

Patient Information

Today's Date_____

Name_____Birth date_____SS#_____

Address_____City_____State_____Zip_____

Home Phone_____Cell_____Work_____

Age_____Email_____

Occupation_____Employer_____

Employer Address_____City_____State_____Zip_____

Sex: [ ] Male [ ] Female # of Children_____Marital Status: [ ] Single [ ] Married [ ] Divorced [ ] Widow

Spouses Name_____Who may we thank for referring you?_____

What type of case will this be? [ ] Medical Insurance [ ] Cash

In case of emergency notify: _____

Phone #_____Alternate Phone #_____

Have you ever seen a chiropractor? [ ] Yes [ ] No If yes, when and why? _____

Last time you were adjusted_____Results_____

Main Reason for consulting our office today_____

Is this due to an injury? [ ] Yes [ ] No If yes, what type of injury?_____

Insurance Information

Primary Insurance_____

Policy #_____Group #_____

Insured's Name_____Insured's Birth Date_____

Insured's SS#_____

Secondary Insurance_____

Policy #_____Group #_____

Insured's Name_____Insured's Birth Date_____

Insured's SS#_____

Assign and Release: I hereby authorize payment of medical benefits to this physician for the services performed. I also authorize the release of any information necessary to process insurance claims on my behalf.

Patient Signature_____**Date**_____

For women only:

[ ] Cramps/backaches-625.3 [ ] Excessive flow-626.2 [ ] Hot flashes-627.2 [ ] Miscarriage-634.9

[ ] Irregular cycle-626.4 [ ] Painful periods- 625.3 [ ] Vaginal discharge-623.5

Are you pregnant now? [ ] Yes [ ] No Last Pap Date :_____By whom_____

Family History

[ ] Heart Attack	[ ] Headache	[ ] Arthritis	[ ] Alcohol/drug abuse
[ ] Dizziness/Vertigo	[ ] Emphysema	[ ] Fainting/drop attacks	[ ] Seizures/Epilepsy
[ ] Diabetes	[ ] Stroke	[ ] Cancer	[ ] Depression/Anxiety
[ ] Osteoporosis	[ ] Anemia	[ ] Digestion difficulties	[ ] Ulcer
[ ] Gout	[ ] Unusual Bleeding		

Operations and Procedures: (Please check all that apply and add date)

[ ] Vaccinations_____ [ ] Tonsillectomy_____ [ ] Gall Bladder_____ [ ] Back operation_____

[ ] Tubes in ears_____ [ ] Appendectomy_____ [ ] Female organs_____ [ ] Rectal surgery_____

[ ] Sinus_____ [ ] Hernia_____ [ ] Thyroid_____ [ ] Stomach_____

Please list any operations or procedures not indicated above:_____

List any accidents or falls and dates(include auto, sports, ect)_____

List any broken bones or dislocations:_____

Ever on crutches? [ ] Yes [ ] No Have you ever had any spinal taps or injections? [ ] Yes [ ] No

Were you ever knocked unconscious? [ ] Yes [ ] No Have you ever had lapse of memory? [ ] Yes [ ] No

Have you ever had x-rays taken? [ ] Yes [ ] No When?_____

For what ailments were these x-rays taken?_____

What other factors of your health, have you nor revealed, if any?_____

Please list any medications you are presently taking (include prescription and over the counter)

_____

I understand that the Doctor and his staff will rely on my answers to this Intake Form, and affirm that my answers are true and complete. I agree to hold the Doctor and his staff harmless for any injury, which I may suffer as a result of my failure to fully complete the Intake From truthfully and accurately. I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that the Doctors office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to the Doctors Office will be credited to my account on receipt. However, I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered me will be immediately due and payable. I hereby authorize the Doctor to examine and treat my condition as he/she deems appropriate through the use of Chiropractic Health Care, and I give authority for these procedures to be performed. It is understood and agreed the amount paid the Doctor for x-rays is for examination only and the x-ray negatives will remain on the property of the office, being on file where they may be seen at any time while a patient of this office. The patient also agrees that he/she is responsible for all bills incurred at this office. The Doctor will not be held responsible for any pre-existing medically diagnosed conditions nor for any medical diagnosis.

Patient/Guardian Signature_____ **Date**_____