4 four

IN EVENT OF EMERGENCY

Who should we contact ?

Relation: _____

Home Phone #: _____

Work Phone #: _____

5 five

HEALTH HISTORY

Are you taking any of the following medications?

❒ Nerve pills ❒ Pain killers (including aspirin) ❒ Muscle relaxer's ❒ Stimulants
❒ Blood Thinners ❒ Tranquilizers ❒ Insulin ❒ Others

Have you ever had any of the following diseases / medical conditions?

Y N Heart Attack / Stroke	Y N Heart surg. / Pacemaker	Y N Heart Murmur
Y N Congenital Heart Defect	Y N Mitral Valve Prolapse	Y N Artificial Valves
Y N Alcohol / Drug Abuse	Y N Venereal Disease	Y N Hepatitis
Y N HIV / Aids	Y N Shingles	Y N Cancer
Y N Frequent Neck Pain	Y N Emphysema / Glaucoma	Y N Anemia
Y N High / Low Blood Pressure	Y N Psychiatric Problems	Y N Rheumatic Fever
Y N Severe / Frequent Headaches	Y N Kidney Problems	Y N Ulcers / Colitis
Y N Fainting / Seizures / Epilepsy	Y N Sinus Problems	Y N Asthma
Y N Diabetes / Tuberculosis	Y N Problems Breathing	Y N Chemotherapy
Y N Lower Back Problems	Y N Artificial Bones / Joints	Y N Arthritis

Please list any other serious medical conditions (s) you have or ever had:

_____

Please list anything that you may be allergic to:

_____

List previous surgeries / treatments with dates:

_____

List any past serious accidents with dates:

_____

Do you smoke? ❒ No ❒ Yes / How much ❒ How long?
Are you wearing: ❒ Heel lifts ❒ Sole lifts ❒ Inner soles ❒ Arch supports
What is the age of your mattress?_____ Is it comfortable? ❒ Yes ❒ No
For women: Are you taking Birth Control? ❒ Yes ❒ No
Are you Pregnant? ❒ No ❒ Yes / How Long____ Nursing? ❒ Yes ❒ No

6 six

ACCOUNT INFO

Person ultimately responsible for account
Name: _____

Relations: _____

Billing Address:

_____
CITY STATE ZIP

S.S.#: _____

D.L.#: _____

Work Phone #: _____

Payment method:
❒Cash ❒Check ❒Credit Card
CC# (if accepted)# _____

❒ I hereby authorize assignment of my insurance rights and benefits directly to the provider for services rendered (if offered at this office)

- We invite you to discuss with us any questions regarding our services. The best health services are based on a friendly, mutual understanding between provider and patient.
- Our policy requires payment in full for all services rendered at the time of visit, unless other arrangements have been made with the business manager. If account is not paid within 90 days of the date of service and no financial arrangements have been made, you will be made responsible for any expenses incurred in collecting your account.
- I authorize the staff to perform any necessary services needed during diagnosis and treatment. I also authorize the provider to release any information required to process insurance claims.
- I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes in my medical status.

Signature_____ Date ___/___/___