Biss Clinic of Chiropractic

New Patient Form - General Information

Last Name:	First	st Name:	MI:	Date:	
Address:		City:	S	tate:Zip	
Social Security #:		E-mail Address:			
Home Phone: ()		Work Phone: ()	Cel	l: ()	
Date of Birth:	Age:	Marital Status:	□ Married	□ Divorced	□ Widowed
Spouse's Name:					
Occupation:		Employer:			

Insurance Information

Who is responsible for this account?	
Relationship to Patient:	
Insurance Provider:	Group Number:
Is patient covered by additional insurance? \Box Yes \Box N	lo Subscriber's Name:
Birthdate: Social S	Security #:
Relationship to patient:	
Insurance Provider:	Group Number:

AGREEMENT AND RELEASE

I certify that I, and/or my dependent(s), have insurance coverage with ______ and assign directly to Dr. ______ all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above-named doctor may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

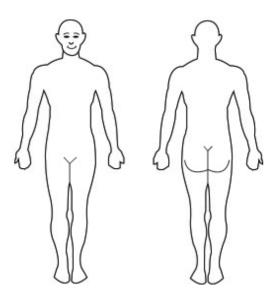
Signature of Patient, Parent, Guardian or Personal Representative

Please print name of Patient, Parent, Guardian or Personal Representative

Patient Conditions and Symptoms

Major Pain or Prob	lem:			
	problem start?			
Is the pain/problem	due to an accident? \Box Ye	es □ No Date:		
Type of accident:	🗆 Auto 🗆 Work 🗆 H	Iome 🗆 Other		
To whom have you	made a report of your acc	ident? 🗆 Auto Insurai	nce 🗆 Employer 🗆 W	Vorker's Comp. 🛛 Other
Attorney Name (if	applicable):			
Rate the Pain:				
No Pain 0	1 2 3	4 5 6	7 8 9 -	10 Extreme Pain
Describe the pain?	□ Sharp □ Dull □	Intermittent 🗆 Cons	tant Frequency:	
What activities agg	ravate the pain?			
	e the pain?			
Does the pain get w	vorse at certain times of the	e day? □ Yes □ No	When?	
Does the pain inter	fere with work? □ Yes	□ No Sleep? □ Yes	□ No Other? □ Yes	□ No
Is the pain getting v	worse? 🗆 Yes 🗆 No			
Other Symptoms:				
□ Headaches	□ Neck Pain	□ Back Pain	□ Chest Pain	□ Dizziness
□ Tension	□ Stiff Neck	□ Irritability	□ Aching	□ Fatigue
□ Fainting	□ Upset Stomach	□ Numbness	□ Swelling	□ Tingling
Other:				

Mark an X on the picture below where you continue to have pain, numbness, and/or tingling.



Health History

What treatment have you received	-	□ Medications	□ Surgery	□ Physical Therapy
\Box Chiropractic Services \Box	None \Box Other			
Name and address of other doctor(s) who have treated you for your condition:				
Date of Last:				
Physical Exam:	Chest X-Ray:		Blood Te	st:
Spinal Exam:	Spinal X-Ray:		Urine Tes	st:
Dental X-Ray:	MRI, CT-Scan,	Bone Scan:		

Place a mark on "Yes" or "No" to indicate if you have had any of the following:

AlcoholismU YesNoGonorrheaU YesNoPneumoniaU YesNoAllergy ShotsI YesNoGoutI YesNoPolioI YesNoAnemiaI YesNoHeart DiseaseI YesNoProstate ProblemI YesNoAnorexiaI YesNoHenriaI YesNoProstate ProblemI YesNoAppendicitisI YesNoHerniaI YesNoProstate ProblemI YesNoArthritisI YesNoHerniaI YesNoProstate ProblemI YesNoAsthmaI YesNoHerniaI YesNoReumatici ArthritisI YesNoBreast LumpI YesNoHigh Blood PressurI YesNoScarlet FeverI YesNoBranchitisI YesNoHigh CholesterolI YesNoScarlet FeverI YesNoBranchitisI YesNoHigh CholesterolI YesNoScarlet FeverI YesNoGancerI YesNoHigraine HeadachesI YesNo	AIDS/HIV	□ Yes □ No	Goiter	□ Yes □ No	Pinched Nerve	□ Yes □ No
Anemia \frac{1}{Yes} \frac{1}{No} Heart Disease \frac{1}{Yes} \frac{1}{No} \frac{1}{Yes} \frac{1}{No} Anorexia \frac{1}{Yes} \frac{1}{No} Hepatitis \frac{1}{Yes} \frac{1}{No} \frac{1}{Yes} \frac{1}{No} Appendicitis \frac{1}{Yes} \frac{1}{No} Hernia \frac{1}{Yes} \frac{1}{No} Prostate Problem \frac{1}{Yes} \frac{1}{No} Arthritis \frac{1}{Yes} \frac{1}{No} Hernia \frac{1}{Yes} \frac{1}{No} Rheumatoid Arthritis \frac{1}{Yes} \frac{1}{No} Asthma \frac{1}{Yes} \frac{1}{No} Herpes \frac{1}{Yes} \frac{1}{No} Rheumatoid Arthritis \frac{1}{Yes} \frac{1}{No} Bleeding Disorders \frac{1}{Yes} \frac{1}{No} High Blood Pressure \frac{1}{Yes} \frac{1}{No} Scarlet Fever \frac{1}{Yes} \frac{1}{No} Bronchitis \frac{1}{Yes} \frac{1}{No} High Cholesterol \frac{1}{Yes} \frac{1}{No} Scarlet Fever \frac{1}{Yes} \frac{1}{No} Gancer \frac{1}{Yes} \frac{1}{No} Higraine Headaches \frac{1}{Yes} \frac{1}{No} Siciele Attempt \frac{1}{Yes} \frac{1}{No} Tossilitis \frac{1}{Yes} \frac{1}{No} Tossilitis \frac{1}{Yes} \frac{1}{No} Tossilitis \frac{1}{Yes} \frac{1}{No} Tossilitis \frac{1}{Yes} \frac{1}{No}<	Alcoholism	□ Yes □ No	Gonorrhea	🗆 Yes 🗆 No	Pneumonia	🗆 Yes 🗆 No
AnorexiaYesYesNoProsthesisYesNoAppendicitisYesYesNoHerniaYesNoPsychiatric CareYesNoArthritisYesNoHerniated DiskYesNoRheumatoid ArthritisYesNoAsthmaYesNoHerpesYesNoRheumatic FeverYesNoBleeding DisordersYesNoHigh Blood PressureYesNoScarlet FeverYesNoBreast LumpYesNoHigh CholesterolYesNoScarlet FeverYesNoBuliniaYesNoLiver DiseaseYesNoStrokeYesNoCancerYesNoMigraine HeadachesYesNoThyroid ProblemsYesNoChicken PoxYesNoMiscarriageYesNoTuberculosisYesNoDiabetesYesNoMutiple SclerosisYesNoTuberculosisYesNoFarcturesYesNoPacemakerYesNoYesNoYesNoGlaucomaYesNoPacemakerYesNoYesNoYesNoNoNoYesNoMutripYesNoYesNoYesNoNoNoYesNoPacemakerYesNoYesNoYesNoCancerYesNoMutripYesNoYes <td< th=""><th>Allergy Shots</th><th>\Box Yes \Box No</th><th>Gout</th><th>□ Yes □ No</th><th>Polio</th><th>\Box Yes \Box No</th></td<>	Allergy Shots	\Box Yes \Box No	Gout	□ Yes □ No	Polio	\Box Yes \Box No
AppendicitisYesYesYesPsychiatric CareYesNoArthritisYesYesYesYesNoRheumatoid ArthritisYesNoAsthmaYesYesYesYesNoRheumatoid ArthritisYesNoBleeding DisordersYesYesYesYesNoScarlet FeverYesNoBreast LumpYesYesNoYesYesNoScarlet FeverYesNoBronchitisYesYesNoYesNoScarlet FeverYesNoBulimiaYesYesNoYesNoScarlet FeverYesNoCancerYesNoYesNoScarlet FeverYesNoChemical DependererYesNoYesNoScarlet FeverYesNoDiabetesYesNoMigraine HeadachesYesNoScarlet FeverYesNoDiabetesYesNoYesNoYesNoScarlet FeverYesNoChemical DependererYesNoMigraine HeadachesYesNoThyroid ProblemsYesNoDiabetesYesNoYesNoYesNoYesNoYesNoGiaucomaYesNoScarlet SeiYesNoYesNoYesNoFracturesYesNoScaporosisYesNoYesNoYesNo <t< th=""><th>Anemia</th><th>□ Yes □ No</th><th>Heart Disease</th><th>🗆 Yes 🗆 No</th><th>Prostate Problem</th><th>🗆 Yes 🗆 No</th></t<>	Anemia	□ Yes □ No	Heart Disease	🗆 Yes 🗆 No	Prostate Problem	🗆 Yes 🗆 No
ArthritisYesNoHerniated DiskYesNoRheumatoid ArthritisYesNoAsthmaYesYesNoHerpesYesNoRheumatoid ArthritisYesNoBleeding DisordersYesNoHigh Blood PressureYesNoScarlet FeverYesNoBreast LumpYesNoHigh CholesterolYesNoScarlet FeverYesNoBronchitisYesNoKidney DiseaseYesNoSexually TransmittedYesNoBulimiaYesNoLiver DiseaseYesNoSiciede AttemptYesNoCancerYesNoMigraine HeadachesYesNoThyroid ProblemsYesNoChemical DependencyYesNoMiscarriageYesNoTuberculosisYesNoDiabetesYesNoMumpsYesNoTuphoid FeverYesNoEmphysemaYesNoScarenaceYesNoYesNoFracturesYesNoPacemakerYesNoYesNoGlaucomaYesNoParkinson's DiseaseYesNoYesNoManconYesNoParkinson's DiseaseYesNoYesNoManconYesNoParkinson's DiseaseYesNoYesNoManconYesNoParkinson's DiseaseYesNoYesNoMancon<	Anorexia	□ Yes □ No	Hepatitis	□ Yes □ No	Prosthesis	\Box Yes \Box No
AsthmaYesYesHerpesYesNoRheumatic FeverYesNoBleeding DisordersYesYesNoScarlet FeverYesNoBreast LumpYesYesNoScarlet FeverYesNoBronchitisYesYesNoYesNoScarlet FeverYesNoBulimiaYesYesNoYesNoScarlet FeverYesNoCancerYesNoMigraine HeadachesYesNoNoNoNoNoChemical DependerYesNoMitripe SclerosisYesNoTuberculosisYesNoDiabetesYesNoMultipe SclerosisYesNoYesNoYesNoFracturesYesNoScenakerYesNoYesNoYesNoGlaucomaYesNoScenakerYesNoYesNoYesNoFracturesYesNoParkinson's DiseaseYesNoYesNoYesNoGlaucomaYesNoParkinson's DiseaseYesNoYesNoYesNoSecondYesNoParkinson's DiseaseYesNoYesNoYesNoSecondYesNoParkinson's DiseaseYesNoYesNoYesNoSecondYesNoParkinson's DiseaseYesNoYesNoYesN	Appendicitis	🗆 Yes 🗆 No	Hernia	□ Yes □ No	Psychiatric Care	□ Yes □ No
Bleeding DisordersI YesI High Blood PressureI YesI NoScarlet FeverYesNoBreast LumpI YesNoHigh CholesterolI YesNoScaully TransmittedI YesNoBronchitisI YesNoI YesI YesNoStrokeI YesNoBulimiaI YesNoI YesI YesNoStrokeI YesNoCancerI YesNoMigraine HeadachesI YesNoNoNoNoNoChemical DependerI YesNoMiscarriageI YesNo <t< th=""><th>Arthritis</th><th>\Box Yes \Box No</th><th>Herniated Disk</th><th>□ Yes □ No</th><th>Rheumatoid Arthritis</th><th>\Box Yes \Box No</th></t<>	Arthritis	\Box Yes \Box No	Herniated Disk	□ Yes □ No	Rheumatoid Arthritis	\Box Yes \Box No
Breast Lump I Yes No I Yes No Bronchitis I Yes No I Yes No Bulimia I Yes No I Yes No Cancer I Yes No Measles I Yes No Cataracts I Yes No Migraine Headaches I Yes No Chicken Pox I Yes No Miscarriage I Yes No Diabetes I Yes No Multiple Sclerosis I Yes No Epilepsy I Yes Steoporosis I Yes No I Yes No Fractures I Yes No Steoporosis I Yes No Yes No Glaucoma I Yes No Steoporosis I Yes No Yes No Parkinson's Disease I Yes No I Yes No Yes No Mutops I Yes No I Yes No Yes No Findepson I Yes No I Yes No Yes No Pacemaker	Asthma	□ Yes □ No	Herpes	□ Yes □ No	Rheumatic Fever	\Box Yes \Box No
BronchitisI YesNoKidney DiseaseYesNoDiseaseBulimiaI YesNoLiver DiseaseI YesNoStrokeI YesNoCancerI YesNoMeaslesI YesNoSuicide AttemptI YesNoCataractsI YesNoMigraine HeadachesI YesNoThyroid ProblemsI YesNoChemical DependencyI YesNoMiscarriageI YesNoTuberculosisI YesNoDiabetesI YesNoMultiple SclerosisI YesNoTumors, GrowthsI YesNoEpilepsyI YesNoSteoporosisI YesNoYesNoYesNoFracturesI YesNoPacemakerI YesNoYesNoYesNoGlaucomaI YesNoParkinson's DiseaseI YesNoYesNoYesNoFracturesI YesNoParkinson's DiseaseI YesNoYesNoYesNo	Bleeding Disorders	□ Yes □ No	High Blood Pressure	□ Yes □ No	Scarlet Fever	□ Yes □ No
BronchitisYesNoKidney DiseaseYesNoBulimiaYesNoLiver DiseaseYesNoCancerYesNoMeaslesYesNoCataractsYesNoMigraine HeadachesYesNoChemical DependencyYesNoMiscarriageYesNoChicken PoxYesNoMultiple SclerosisYesNoDiabetesYesNoYesNoEmphysemaYesNoYesNoFracturesYesNoPacemakerYesNoGlaucomaYesNoParkinson's DiseaseYesNo	Breast Lump	□ Yes □ No	High Cholesterol	□ Yes □ No	v	□ Yes □ No
BulimiaI YesLiver DiseaseYesNoCancerYesYesNoYesNoCataractsYesYesNoYesNoChemical DependencyYesNoYesNoThyroid ProblemsYesChicken PoxYesNoYesNoTuberculosisYesNoDiabetesYesNoYesNoYesNoYesNoEmphysemaYesNoYesNoYesNoYesNoFracturesYesNoPacemakerYesNoYesNoGlaucomaYesNoParkinson's DiseaseYesNoYesNoYesYesNoYesYesYesYesYesYesYesYesNoYesYesYesYesYesYesParkinson's DiseaseYes <th>Bronchitis</th> <th>□ Yes □ No</th> <th>Kidney Disease</th> <th>□ Yes □ No</th> <th></th> <th>□ Yes □ No</th>	Bronchitis	□ Yes □ No	Kidney Disease	□ Yes □ No		□ Yes □ No
CancerYesNoMeaslesYesNoCataractsYesNoMigraine HeadachesYesNoChemical DependencyYesNoYesNoTonsillitisYesChicken PoxYesNoMononucleosisYesNoDiabetesYesNoMultiple SclerosisYesNoEmphysemaYesNoYesNoEpilepsyYesNoYesNoFracturesYesNoYesNoGlaucomaYesNoYesNo	Bulimia	□ Yes □ No	Liver Disease	□ Yes □ No		
CataractsYesNoMigraine HeadachesYesNoChemical DependencyYesNoYesNoTonsillitisYesNoChicken PoxYesNoYesNoYesNoTuberculosisYesNoDiabetesYesNoYesYesNoYesNoYesNoEmphysemaYesNoYesNoYesNoYesNoFracturesYesYesNoYesNoYesNoGlaucomaYesNoParkinson's DiseaseYesNoYesNo	Cancer	□ Yes □ No	Measles	□ Yes □ No	-	
Chemical DependencyYesNoMiscarriageYesNoChicken PoxYesNoMononucleosisYesNoDiabetesYesNoYesNoTumors, GrowthsYesDiabetesYesNoYesNoEmphysemaYesNoYesNoEpilepsyYesNoYesNoFracturesYesNoYesNoGlaucomaYesNoYesNo	Cataracts	\Box Yes \Box No	Migraine Headaches	\Box Yes \Box No	·	
Chicken PoxYesNoMononucleosisYesNoDiabetesYesNoMultiple SclerosisYesNoEmphysemaYesNoMumpsYesNoEpilepsyYesNoOsteoporosisYesNoFracturesYesNoPacemakerYesNoGlaucomaYesNoParkinson's DiseaseYesNo	Chemical Dependency	v □ Yes □ No	Miscarriage	□ Yes □ No		
DiabetesYesNoMultiple SclerosisYesNoEmphysemaYesNoMumpsYesNoEpilepsyYesNoOsteoporosisYesNoFracturesYesNoPacemakerYesNoGlaucomaYesNoParkinson's DiseaseYesNo	Chicken Pox	\Box Yes \Box No	Mononucleosis	\Box Yes \Box No		
EmphysemaYesNoMumpsYesNoEpilepsyYesNoOsteoporosisYesNoFracturesYesNoPacemakerYesNoGlaucomaYesNoParkinson's DiseaseYesNo	Diabetes	□ Yes □ No	Multiple Sclerosis	□ Yes □ No		
EpilepsyYesNoOsteoporosisYesNoFracturesYesNoPacemakerYesNoGlaucomaYesNoParkinson's DiseaseYesNo	Emphysema	\Box Yes \Box No	Mumps	\Box Yes \Box No	• •	
Fractures Yes No Pacemaker Yes No Glaucoma Yes No Parkinson's Disease Yes No	Epilepsy	□ Yes □ No	Osteoporosis	□ Yes □ No	Vaginal Infection	
Glaucoma 🗆 Yes 🗆 No Parkinson's Disease 🗆 Yes 🗆 No	Fractures	□ Yes □ No	Pacemaker	\Box Yes \Box No	0	
Are You Pregnant?	Glaucoma	□ Yes □ No	Parkinson's Disease	□ Yes □ No	Are You Pregnant?	□ Yes □ No

Health History (cont.)

EXERCISE: D None D Moderate WORK ACTIVITY: Sitting D St		Labor
HABITS:		
□ Smoking	Packs/Day:	
□ Alcohol	Drinks/Week:	
□ Coffee/Caffeine Drinks	Cups/Day:	
□ High Stress Level	Reason:	
Injuries/Surgeries you have had	Description	Date
Falls		
Head Injuries		
Broken Bones		
Dislocations		
Surgeries		
MEDICATIONS A	ALLERGIES	VITAMINS/HERBS/MINERALS

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that the Doctor's 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 Doctor's 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 the property of this 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.