DATE_____/_____/_____
NAME_____ BIRTH DATE ___/___/___ AGE_____
ADDRESS_____ APT. _____ CITY_____STATE_____
ZIP_____ PHONE_____ CELL_____
PREFERRED METHOD OF CONTACT ❑ Phone ❑ Cell
EMAIL_____ ❑Male ❑ Female ❑ Married ❑ Single ❑Widow ❑ Divorced ❑ Sep
SOC SEC _____/_____/_____ OCCUPATION_____
EMPLOYER_____ WORK PHONE _____
SPOUSE_____ OCCUPATION_____
EMERGENCY CONTACT NAME _____PHONE _____
RF ❑FAMILY ❑FAMILY DOCTOR ❑ INTERNET ❑LECTURE ❑YELLOW PAGES

PAST HISTORY

MOTHER (AGE) _____ FATHER (AGE) _____ YOUR CHILDREN (AGES) _____
History: Have you ever had
❑TB ❑CANCER ❑EPILEPSY ❑DIABETES ❑ARTHRITIS ❑ASTHMA ❑HEART DISEASE ❑SINUS ❑KIDNEY
❑ HEPATITIS ❑HIV-AIDS ❑POLIO ❑THYROID DISEASE ❑ALCOHOL/DRUG DEPENDENCY OTHER _____
Have <u>you</u> ever had: MUMPS ❑ MEASLES ❑ CHICKEN POX ❑
PREVIOUS CHIROPRACTIC TREATMENT (Where and When) _____
SURGERY_____
FRACTURES_____
PREVIOUS
INJURIES/ACCIDENTS_____
LIST MEDICATION/ VITAMINS? _____
_____
ARE YOU PREGNANT? ❑YES ❑NO LAST MENSTRUAL PERIOD _____

INSURANCE

THE CLINIC POLICY REQUIRES PAYMENT ARRANGEMENTS BE MADE ON THE FIRST VISIT-if yours is an auto accident or work comp case, inform the Eisman Clinic Team member at the front desk.

NAME OF PARTY RESPONSIBLE FOR PAYMENT_____
DO YOU HAVE INSURANCE? YES ❑ NO❑ BLUE CROSS ❑ MEDICARE ❑ MEDICAID ❑
OTHER _____ SECONDARY INS _____
SPOUSE'S INS_____ SPOUSE'S DATE OF BIRTH ___/___/___ SPOUSE'S SOC SEC_____/_____/_____
AUTO ❑ WORK COMP ❑ INSURANCE NAME_____ CLAIM NO. _____
ATTORNEY'S NAME_____ PHONE_____
R/F_____

Financial Policy-I understand and agree that my insurance policies are an arrangement between the insurance company and myself. The clinic, as a courtesy to you, will bill your insurance company. I authorize my insurance company to pay the Eisman Clinic, P.C. directly. All monies paid will be applied to my account. However, I clearly understand and agree that all services rendered to 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, any fees for professional services rendered to me will be immediately due and payable. Some plans may not cover the entire bill or may refuse to pay. You will be responsible to pay any unpaid balance. If you do not have insurance, then all services are paid per visit or in advance.

Please speak to the doctor about payment/family plans. I authorize the Eisman Chiropractic Clinic to release all records as needed for the purpose of collecting bills for services that I may or will incur. Records may be sent via mail or electronically (fax or email) as deemed by the Eisman Clinic. **I understand and agree to the financial policies of the Eisman Clinic, P.C.**

_____ _____

Signature **Date**