Welcome to

biles family CHIROPRACTIC

NEW PATIENT INFORMATION

Please Complete All Questions

Name: _____ **Date:** _____

Address: _____

City: _____ **State:** _____ **Zip:** _____

Home Phone: _____ **Work Phone:** _____

Your Employer: _____ **Occupation:** _____

Birth Date: _____ **Age:** _____ **Social Security #:** _____

Marital Status: M D S W **E-mail Address:** _____

Spouse's Name: _____ **Occupation:** _____

Children's Name and Ages: _____

Method of payment for first visit: **Cash** **Check** **Credit Card**

Who may we thank for referring you? _____

-Do you have health insurance that covers chiropractic? **Yes** **No**

-If so, would you like necessary paper work for reimbursement? **Yes** **No**

Current Health Concerns/ Reasons for Consulting Our Office:

1. _____ **How Long?** _____

2. _____ **How Long?** _____

-Have you had the same or similar problem(s) before? _____

-If so, for how long? _____

-Is this the result of an auto or work injury? _____ **If so, when?** _____

-Father, mother, sibling, children with similar problems? _____ **Who?** _____

-Other doctors you have seen for this condition: _____

-List any surgeries you have had: _____

-List any prescription drugs you are taking: _____

-Have you ever been diagnosed with cancer? _____ **If so, what kind?** _____

-Is there a family history of:

_ Heart Disease _ Arthritis _ Cancer _ Diabetes _ Other _____

-Women Only: Is there any chance you are pregnant? **Yes** **No**

Other Symptoms:

_ Headaches	_ Face Flushed	_ Light Bothers Eyes
_ Neck Pain	_ Neck Stiff	_ Loss of Memory
_ Sleeping Problems	_ Pins & Needles in Legs	_ Ears Ring
_ Back Pain	_ Pins & Needles in Legs	_ Fever
_ Nervousness	_ Numbness in Fingers	_ Fainting
_ Tension	_ Numbness in Toes	Cold Sweats
_ Irritability	_ Shortness of Breath	_ Loss of Smell
_ Chest Pains	_ Fatigue	_ Loss of Taste
_ Dizziness	_ Depression	_ Diarrhea
_ Feet Cold	_ Loss of Balance	_ Stomach Upset
_ Hands Cold	_ Buzzing in Ear	_ Constipation

X-Ray Consent

In the course of your examination we may determine that it is necessary to perform an x-ray examination of your spine and/or extremity.

I hereby authorize the doctors of this office to perform spinal and/or extra spinal x-ray examinations on me with my consent.

Signature _____

Pregnancy Release

This is to certify that to the best of my knowledge I am not pregnant and that Dr. Laura Biles has my permission to perform an x-ray evaluation. I have been advised that x-rays can be hazardous to an unborn child. Date of last menstrual period:_____.

As a result of my chiropractic care, I would like to:

Please check all that apply

_ Feel better quickly	_ Live a healthier lifestyle
_ Have a healthier spine	_ Have a healthier body by keeping my nerve system healthy

The above information is true and accurate to the best of my knowledge.

Patient or Guardian Signature:_____Date:_____

TERMS OF ACCEPTANCE

When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for both to be working towards the same objective.

Chiropractic has only one goal. It is important that each patient understand both the objective and the method that will be able to attain it. This will prevent any confusion or disappointment.

Adjustment: An adjustment is the specific application of forces to facilitate the body's correction of vertebral subluxation. Our chiropractic method of correction is by specific adjustments of the spine.

Health: A state of optimal physical, mental and social well-being, not merely the absence of disease or infirmity.

Vertebral Subluxation: A misalignment of one or more of the 24 vertebra in the spinal column which causes alteration of nerve function and interference to the transmission of mental impulses, resulting in a lessening of the body's innate ability to express its maximum health potential.

We do not offer to diagnose or treat any disease or condition other than vertebral subluxation. However, if during the course of a chiropractic spinal evaluation, we encounter non-chiropractic or unusual findings, we will advise you. If you desire advice, diagnosis or treatment for those findings, we will recommend that you seek the services of a health care provider who specializes in that area.

Regardless of what the disease is called, we do not offer to treat it. Nor do we offer advice regarding treatment prescribed by others. **OUR ONLY PRACTICE OBJECTIVE** is to eliminate a major interference to the expression of the body's innate wisdom. Our only method is specific adjusting to correct vertebral subluxations.

Consent to evaluate and adjust a minor child

I,_____being a parent or legal guardian of_____ _____have read and fully understand the above terms of acceptance and hereby grant permission for my child to receive chiropractic care from Dr. Laura Biles and whomever she may designate as her assistant(s).
Parent or Guardian Signature:_____ Date:_____ _____

Consent For Treatment
I, the undersigned, a patient in this office, hereby authorize Dr. Laura Biles, D.C. (and whomever she may designate as her assistant(s)) to administer treatment as is necessary. I also certify that no guarantee or assurances have been made to me as to the results that may be obtained. I understand and agree that health and accident insurance policies are an agreement between the insurance company and myself. Furthermore, I understand that this office will prepare any necessary reports and forms to assist me in making collection to my account upon receipt. I permit this office to endorse remittances for the conveyance of credit 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.
Initials:_____ Date:_____

I have read and fully understand the above statements. All questions regarding the doctor's objective pertaining to my care in this office have been answered to my compete satisfaction. I therefore accept chiropractic care on this basis.

Signature:_____ Date:_____