NEW PATIENT INFORMATION

Name ________________________ Address ______________________________________
City/State/Zip_____________________________ Home Phone ______________________
Cell Phone___________________ Can we text you apt reminders? Y or N
SSN _________________ Birthday ___________ Age ______ Male __ Female __
Occupation ____________________ Employed by _______________________________
# of children ______ Children's Age _______________________ M __ S __ D __ W __
Spouse Name ______________ E-mail address ____________________________Y or N
Previous Chiropractic Care? _______ Who? ________________ When? _____________
Who may we thank for referring you to us? _____________________________________

List your chief complaints in order of severity:
1. ___________________________________ For how long? _________________
2. ___________________________________ For how long? _________________
3. ___________________________________ For how long? _________________

List other doctors consulted for these conditions:
1. ____________________________________ Address ___________________________
2. ____________________________________ Address ___________________________

List surgeries and dates:
1. ____ Date ____________
2. ____ Date ____________

List all drugs you now take (prescription and non-prescription) _________________
____
____

Is this injury work-related? Y N   Reported to your employer? Y N
Is this injury or illness related to an automobile accident? Y N
List any falls/accidents in last 5 years: ____
____

What are your health goals? ____
How do you expect to achieve these goals?_____________________________________

Please mark if you have had any of these symptoms in the last 12 months:

___ Fractured bones
___ Auto Accidents
  ___ 0-1 years ago
  ___ 1-5 years ago
  ___ 5 years or more
___ Other accidents, falls
___ Arthritis
___ Diabetes
___ Convulsions, epilepsy
___ Skin problems
___ Cancer
___ Irritability
___ Anemia
___ Allergy, sinus
___ Under stress
___ Eating disorders
___ Trouble sleeping
___ Trouble concentrating
___ Learning disability
___ Mood Changes

___ Neck pain or stiffness R L
___ Numbness/tingling, pain in arms, hands, fingers R L
___ Jaw pain or click (TMJD) R L
___ Difficulty in excessive standing, sitting, riding, bending, lifting, twisting,
___ Shoulder pain R L
___ Dizziness
___ Ringing in ears R L
___ Hearing loss R L
___ Blurred or doubled vision
___ Upper back pain, stiffness
___ Lower back pain, stiffness
___ Pain with cough, sneeze
___ Hip Pain R L
___ Headaches
___ Numbness, tingling, pain in buttocks, legs, feet, toes R L

(OVER PLEASE)

___ Foot trouble R L
___ Chest pain, asthma
___ Heart problems
___ Stroke
___ High/low blood pressure
___ Varicose veins
___ Liver trouble
___ Gall bladder trouble
___ Digestive problems
___ Ulcers
___ Hemorrhoids
___ Prostate problems
___ Impotence
___ Kidney trouble
___ Menstrual problems (PMS)
___ Menopause problems
___ Pregnant (NOW)
___ Bed wetting
___ Ear Infections
___ AIDS, HIV
___ High cholesterol, triglycerides

POLICIES

1. All first visit charges are payable when services are rendered.

2. The fee paid for x-rays is for analysis only. The film itself is the property of this office and will be released to any requesting physician for review with patient signature. Copies can be made, if necessary, at the expense of those who request them.

3. Method of payment you plan to use to take care of today's charges
   - CASH -CHECK -DEBIT -VISA/MASTERCARD

4. DISCLOSURE OF INTEREST:
   WE CHARGE .83% INTEREST PER MONTH ON ANY OUTSTANDING BALANCE (30+ DAYS) AS ALLOWED BY ARIZONA STATE LAW.

5. By law we keep all records including x-rays for 7 years.

6. The cancellation policy of this office requires patients to notify our office staff of all cancellations/rescheduling **no later than 8:00am the day prior to the appointment. Missed appointments without timely notification will be charged to the patient.**

I understand and agree that health and accident insurance policies are an arrangement between my insurance carrier and me. Dr. Hancock is not a participating provider with any medical insurance company and I understand that Hancock Chiropractic Clinic will prepare upon request, an itemized statement for me to submit to my insurance company. I understand that Dr. Hancock only accepts assignment on Medicare Part A&B and not on any Medicare replacement coverage. Hancock Chiropractic Clinic submits all Medicare claims for the patient. Any amount paid directly to Hancock Chiropractic Clinic by my medical insurance company that has already been paid by me will be credited to my account upon receipt. **However, I clearly understand and agree that all services rendered me are charged directly to me and I am personally responsible for payment in every case except verified Workman's Compensation cases.**

In case of emergency notify ___________________________ Relationship ____________

Address _____________________________ Phone Number ____________________

____

Patient Signature ____ Date ____________

(IF PATIENT IS A MINOR)
I hereby state that I am the parent or legal guardian of ________________ and I give my permission to Dr. Hancock to treat him/her.

Signed ____________________________ Relationship _____________ Date _________

Rev 1-1-16