PATIENT INFORMATION TODAY'S DATE: ______________

Name: ______________________________________ Date of Birth: ___________________

Address: _________________________________ City: _________________ zip: _____________

Home Phone: ____________________ Work: ______________________ Cell: _________________

Gender: M/F Marital Status: M S D W Email: ________________________________

Emergency Contact:____________________ Relationship:_____________ Phone:________________

How did you hear about out office?: ______________________________ SSN:_______________

Primary Insurance Carrier: ____________________________ Subscriber: _____________________

Relationship: ________________Subscriber DOB: ______________ Subscriber SSN: _____________

Secondary insurance Carrier: ___________________________Subscriber: __________________

Relationship: ________________Subscriber DOB: ______________ Subscriber SSN: _____________

Family Medical History PLEASE CIRCLE M for Mother's Family F for Father's Family

M/F CANCER	M/F STROKE	M/F SEIZURES	M/F HIGH BLOOD PRESSURE
M/F BACK PAIN	M/F HEART DISEASE	M/F DIABETES	M/F EPILEPSY

MEDICAL HISTORY

___allergies	___dislocations	___muscular dystrophy	___anemia
___epilepsy	___liver problems	___kidney disorders	___asthma
___headaches	___neck pain	___rheumatic fever	___back pain
___heart troubles	___measles	___HIV/AIDS	___polio
___rheumatoid arthritis	___bladder trouble	___high blood pressure	___cancer
___poor circulation	___concussion	___convulsions	___bowel control loss
___scarlet fever	___serious injury	___sinus trouble	___indigestion
___multiple sclerosis	___thyroid issue	___Alzheimer's	___Parkinson's
___bone fracture	___diabetes	___numbness	___tuberculosis

Have you been treated by a physician for any health conditions in the last year? YES or NO

Describe condition: ____________________ Date of last physical exam: ____________________

Who is your Primary Care Physician? ____________________ Clinic: ____________________

MAJOR SURGICAL HISTORY:

1) ____ Date: ____________________

2) ____ Date: ____________________

3) ____ Date: ____________________

ACCIDENT HISTORY:

____Job ____ Auto _____Other 1) ____________________________ Date: ________________

____Job ____ Auto _____ Other 2) ____________________________ Date: ________________

MAJOR COMPLAINTS:

How did your symptoms develop? _____Job related _____Auto Accident _____Illness_____Unknown

Date Occurred: ____________________ Please Explain: ____________________________

____

Complaint 1) __________________________________ Pain Level (Mild 1 2 3 4 5 6 7 8 9 10 Severe)

Type of Pain: Dull Aching Sharp Pinching Grinding

Complaint 2) __________________________________ Pain Level (Mild 1 2 3 4 5 6 7 8 9 10 Severe)

Type of Pain: Dull Aching Sharp Pinching Grinding

Complaint 3) __________________________________ Pain Level (Mild 1 2 3 4 5 6 7 8 9 10 Severe)

Type of Pain: Dull Aching Sharp Pinching Grinding

Are you allergic to any medications? NO /YES Please list: ____________________

Are you currently taking any medications? NO /YES

Please list dose and frequency:

____

____

____

____

Are you pregnant? ___No Last Cycle: ____________ ___Yes Due date: ____________

Please check the following activities that aggravate your condition:

____Bending ____Reaching ____Straining @ Stool ____Coughing ____Turning head

____Lifting ____Sneezing ____Walking ____Standing ____Lying down ____Sitting

Please c heck the following activities that relieve your condition:

____Bending ____Reaching ____Turning head ____Lifting

____Walking ____Standing ____Lying down ____Sitting

Please check any additional symptoms you may be experiencing:

___Blurred vision ___Insomnia ___Buzzing in ears ___Sensitive to light

___Cold feet/hands ___Loss of balance ___Cold sweats ___Loss of taste

___Stiff neck ___Muscle jerking ___Headaches ___Constipation

___Numbness in fingers ___Ringing in ears ___Diarrhea ___Shortness of breath

___Dizziness ___Confusion ___ Flushed Face ___Indigestion

___Fatigue ___Depression ___Weeping Spells ___Fever

___Head feels heavy ___ Muscle Spasms ___Joint Cracking ___Numbness in toes

Array Medical Center

This office makes every possible attempt to maintain patient privacy as per HIPPA (1996).

APPOINTMENTS: Patients are seen by appointment. For urgent and acute situations, we often schedule "work-in" appointments. Work-in appointments are made to address one acute problem, only so that patients with scheduled appointments are not kept waiting. We apologize in advance for any unforeseeable delay you may experience. ***If you are more than 15 minutes late for your appointment, you will be asked to reschedule. Cancellations must be made 24 hours prior to your appointment.***

>>>>>WE CHARGE $25.00 FOR MISSED APPOINTMENTS<<<<<

SOCIAL SECURITY NUMBERS: We handle patient social security numbers and personal information in a confidential manner, but we may release personal and medical information to another doctor's office in the event of a referral. We use social security numbers for insurance and billing purposes. This is required information that we ask from each of our patients.

MINORS: All children under the age of 18 must be accompanied by a parent or guardian. If the parent or guardian is not present, the appointment will be rescheduled. Please do not leave child unattended in the waiting area. A staff member will always be available to sit with your child during your treatments if needed.

CONDUCT: The golden rule **"Treat other's as you wish to be treated"** will be followed in our office at all times. If you as a patient cannot be kind to the staff or other patrons we ask that you kindly reschedule. If you see any misconduct inform a staff member who can assist you.

PAYMENT: Payment is due from each patient at the time of service. We accept several different kinds of payment options. We gladly accept cash, check, Visa, Master Card, Discover, American Express, HAS and HRA.

INSURANCE: We participate with several major insurance carriers. Our office policies concerning the deductible and HSA/HRA plans are as follows: Patients are responsible for their coinsurance, deductibles, and co pays in full. Payment is due at the time of service and is based on the patient's insurance company's contracted rates.

DIVORCEMENT: We reserve the right to refuse service to anyone at anytime for any reason. If our clinic makes the decision to divorce you as a patient you will receive a written notice. In addition you will be given 30 days to find your new primary care provider before we completely refuse to schedule you.

ACKNOWLEDGEMENT: I have read, understand, and agree to follow the above office policies.

Patient / Guardian Signature:______________________________ Date:________

Printed Name of Patient:____

ARRAY MEDICAL CENTER – CONSENT TO TREAT

I hereby request and consent to treatment by the providers in this office. I understand and consent to be evaluated physically. I consent to the performance of chiropractic manipulation, manual therapy techniques, other chiropractic procedures, including but not limited to various types of physical therapeutic activities and modalities. I consent to other procedures whether medical, chiropractic, or therapeutic such as diagnostic tests, exams, evaluations or x-rays when warranted on me) or the minor named below who I am legally responsible for) by the Doctor of Chiropractic, family nurse practitioner practicing in this office and/or any future practitioners of this office or their technicians.

I understand and am informed that results are not guaranteed.

I understand and am informed that in the practice of medicine, the practice of chiropractic, there are some risks to treatments and services including but not limited to:

Manipulation: Increased pain or discomfort, fractures, disc injuries, strokes, dislocations and sprains.

Therapeutic Modalities and Procedures: Additional pain or discomfort. Exercise and/or massage may cause increased risk of acute myocardial infarction (heart attack) in patients with known or possible cardiac conditions.

Radiographs: Ionizing radiation can be harmful to a fetus for those who are pregnant or might be pregnant.

Allergy testing and treatment: Local reactions including but not limited to redness, itching and swelling. Systemic reactions including but not limited to rashes, sneezing, nasal stuffiness, cough, chest tightness, shortness of breath, wheezing or anaphylactic shock.

I do not expect the doctor or support staff to be able to explain or anticipate all possible risks and complications associated with treatments. I wish to rely upon the Doctor (s), F.N.P, and support staff to exercise judgement during the course of my procedures, which are felt at the time, based upon the facts then known to him or her, to be in my best interest.

I have read or have had read to me the above consent. I have also had an opportunity to ask any questions about the content. By signing below, I agree to have the above-named procedures/practices. I intend this consent form to cover the entire course of my treatment in this office for my present condition and/or any past or future condition(s) for which I seek treatment.

Printed Name of Patient: ______________________________

Patient or Guardian Signature: ______________________________

Today's Date: ________________