

**PERSONAL HISTORY** — Dear Patient: In order for us to understand your condition properly, please be as neat and accurate as possible while completing this form. Please give your insurance card to the receptionist, she will make a copy for our records. Thank You. Hansen Chiropractic

**Patient Information**

Last Name _____	Birth Date _____	Age _____
First Name _____ Middle Initial _____	Sex <input type="checkbox"/> M <input type="checkbox"/> F	No. of Children _____
Address _____	SSN _____	
City _____	Marital Status <input type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced	
State/Zip _____	Spouse Name _____	
Phone _____	Parent or Guardian _____	
Cell _____	Referred By _____	
Email _____	If referred by internet please indicate which site.	

**Employer Information**

Occupation _____	Student <input type="checkbox"/> Full Time <input type="checkbox"/> Part Time
Employer _____	Email _____
Address _____	Website _____
City _____	
State/Zip _____	
Work Phone _____	
Fax _____	

**Insurance Information**

Which insurance policy is to be used?  Health  Auto  Workers Comp  Other

1 <sup>st</sup> Insurance _____	Policy/ID No. _____
2 <sup>nd</sup> Insurance _____	Policy/ID No. _____
Attorney _____	Attorney Phone No. _____

**Insured's Information – Policy Holder**

Last Name _____	Insurance ID No. _____
First Name _____ Middle Initial _____	Sex _____
Address _____	Relationship <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Dependant <input type="checkbox"/> Other
City _____	Birth Date _____
State _____	Emp / School _____
Phone _____	Ins. Card Effective Date _____
Cell _____	Ins. Card Expire Date _____

I hereby authorize the Doctor to treat my condition as he deems appropriate through the use of adjusting throughout my spine. It is understood and agreed the amount paid the Doctor for X-rays is for examination only, the X-ray(s) will remain the property of this office. Furthermore, I understand and agree that the Doctor will not be held responsible for any pre-existing medically diagnosed conditions, nor any medical diagnosis. 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. Furthermore, I agree to pay cost and/or reasonable attorney's fees including charges of commission up to 50% that may be assessed to us by any collection agency retained to pursue this matter. I have read and understood this agreement and by my signature below agree to all herein.

\_\_\_\_\_  
PATIENT'S OR AUTHORIZING SIGNATURE \_\_\_\_\_  
DATE

I understand that the Patient Privacy Policies (HIPPA) are available for me to read at the front desk.

\_\_\_\_\_  
PATIENT'S OR AUTHORIZING SIGNATURE \_\_\_\_\_  
DATE

**For Women Only:** X-RAY CONFIRMATION: This is to confirm that I have been advised by the Doctor that X-rays can be hazardous to an unborn child. At this time, to the best of my knowledge, I am not pregnant and I consent to radiographic pictures.

\_\_\_\_\_  
PATIENT'S OR AUTHORIZING SIGNATURE \_\_\_\_\_  
DATE

**For Children Only:** CONSENT TO TREAT A MINOR CHILD: I hereby authorize the doctor to administer chiropractic care as deemed necessary to my SON/DAUGHTER,

Child's Full Name \_\_\_\_\_ PARENT'S OR GUARDIAN'S SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_