DeGraffenreid Chiropractic P.A.

Patient Information

Welcome

The doctor and staff of *DeGraffenreid Chiropractic P.A.* welcome you and want to provide you with the best possible care. We will conduct a thorough history and examination to decide if we can assist you. If we do not believe that your condition will respond to chiropractic care, we will not accept you as a patient but will refer you to another health care provider, if appropriate.

Insurance

This office will process your insurance forms upon request. We will do our utmost to provide sufficient information to your carrier to obtain payment for your treatment. We have found that, in some instances, however, insurance companies will deny or reduce payment despite our best efforts to demonstrate the necessity for care. In the event that full payment is not made for any reason, you must understand that you are responsible to make payment in full.

Patient Identification

Name_____

Street_____

_____
City, State, Zip

E-Mail address_____

_____
Social Security #

( ) Male ( ) Female

Married? ( ) Yes ( ) No

_____
If yes, Spouse's Name and Date of Birth

Name or Nickname I prefer to be called in this office _____

Telephone (Home) _____
(Cell) _____
(Work) _____

OK to call these? ( ) Yes ( ) No

_____
Occupation

Date of Birth_____ Age_____

Females only:
Are you pregnant today? ( )Yes ( )No
Do you give consent for X-Rays if indicated upon exam? ( ) Yes ( ) No

Contact in case of emergency, Name_____

Phone #_____

Name of parent of Minor (If applicable) _____

How did you hear of our office? _____

Confidential Communications Preference: Cell Phone( ) Home Phone( )
Work Phone( ) E-Mail( ) Postal Mail( ) In Person( )

Preferred Language: English( ) Spanish( ) French( ) German( )
Italian( ) Russian( ) Chinese( ) Korean( )
Portuguese( ) Japanese( ) Vietnamese( )

Ethnicity: Not Hispanic or Latino( ) Hispanic or Latino( )

Race - Choose One or More:

White( ) American Indian or Alaska Native( )
Black or African American( ) Asian( )
Declined to Answer( ) Native Hawaiian or other Pacific Islander( )

Medication List (please indicate generic or brand name)**:** _____
_____
_____
_____
_____

Known Drug Allergies (please indicate date of allergic reaction and what reaction was)**:**
_____
_____

Acceptance as a Patient

I understand and agree that the doctor of DeGraffenreid Chiropractic P.A. has the right to refuse to accept me as a patient at any time before treatment begins. The taking of a history and conducting of an examination are not considered treatment, but are part of the process of information gathering so that the doctor can determine whether to accept me as a patient.

Open Adjusting Policy

This office utilizes an adjusting style known as open bay adjusting. During the course of your treatment other patients have the opportunity to observe and overhear your treatment procedures and protocols. It is because these important privacy issues are compromised that we offer a closed door treatment upon request. Hopefully this causes no inconvenience.

Signature_____

Printed Name_____

Date_____