Patient number_____ DATE_____

CONFIDENTIAL CASE HISTORY FORM

PATIENTS FULL NAME_____AGE_____BIRTHDATE_____

SEX_____HOME PHONE #_____BUSINESS PHONE #_____

MAILING ADDRESS_____City, State/Zip:_____

Occupation:_____Spouse:_____OCCUPATION_____

ADDRESS(IF DIFFERENT FROM ABOVE)_____

YOUR S.S.#_____SPOUSES S.S.#_____MARITAL STATUS M__S__D__W__

WHO REFERRED YOU HERE_____DO YOU USE TOBACCO____ALCOHOL_____

NAME OF INSURANCE CO_____POLICY #_____GROUP #_____

NAME OF INSURED (ON POLICY)_____

WERE YOU INJURED ON THE JOB?____DID YOU NOTIFY YOUR EMPLOYER?____NAME OF YOUR COMPANYS WORKMENS COMPENSATION INSURANCE_____

IF THIS VISIT IS DUE TO AN ACCIDENT (AUTO OR OTHERWISE) PLEASE DESCRIBE_____

_____

DESCRIBE YOUR PRESENT PROBLEM_____

HAVE YOU EVER HAD THE PROBLEM BEFORE?____WHEN?_____

WHEN DID IT START THIS TIME?_____

HAVE YOU EVER BEEN TO A CHIROPRACTOR BEFORE?_____WHEN?_____NAME?_____

RESULTS_____

HAVE YOU BEEN TREATED FOR THIS BY AN M.D.?_____HIS NAME_____

HIS DIAGNOSIS_____RESULTS_____

ARE YOU TAKING ANY MEDICATION?_____IF SO, WHAT KIND?_____

WHAT OPERATIONS HAVE YOU HAD?_____

HAVE YOU EVER HAD ANY BROKEN BONES?_____NAME THEM_____

ANY BAD FALLS IN YOUR LIFETIME?_____DESCRIBE_____

ANY AUTOMOBILE ACCIDENTS?_____

DO YOU HAVE REASON TO THINK YOU MAY BE PREGNANT?_____

DO YOU WISH ONLY EMERGENCY TREATMENT_____OR DO YOU PLAN FOR US TO CORRECT THE CAUSE OF YOUR PROBLEM AND KEEP IT CORRECTED?_____

PLEASE CHECK THE FOLLOWING CONDITIONS THAT YOU HAVE HAD IN THE PAST OR HAVE NOW:
(if you have the condition now, place an "N" in the space, if before place a "B")

_____HEADACHES	_____LOW BACK PAIN	_____HAYFEVER, COLDS
_____INDIGESTION, GAS	_____UPPER BACK PAIN	_____DIABETES
_____SINUS TROUBLE	_____FEMALE PROBLEMS	_____CONSTIPATION
_____NERVOUSNESS	_____HIGH BLOOD PRESSURE	_____STOMACH, GALL BLADDER
_____KIDNEY TROUBLE	_____LOW BLOOD PRESSURE	_____NUMBNESS, CRAMPS
_____ARTHRITIS	_____UNABLE TO SLEEP	_____ANY OTHER CONDITIONS
	_____NECK PAIN	

Dr. Philip M. Lawrence
Office Policy - Please Read Carefully

Dear New Patient:

Today you will receive the necessary x-rays and an adjustment. The x-ray charges are $35 for each cervical (neck) view, and $45 for each lumbo-sacral (pelvic) view. The office visit charge is $40. Payment in full is expected today by either cash, check, debit or credit card (we accept Visa, MasterCard, and Discover) unless arrangements have been made in advance.

We are happy to file your insurance *once your bill is paid in full*. Dr. Lawrence does not belong to any PPO or HMO organizations, therefore a $10 or $15 co-pay does not apply in our office. We do not participate in Medicare or Medicaid programs.

ATTENTION AUTO ACCIDENT PATIENTS: You are responsible for any charges incurred here and once you have paid us, we will be happy to send information to your car insurance stating you have paid us and they will reimburse you. We no longer work on a lien basis with attorneys. If you have hired an attorney, we will send them your records for you once you are released, but *you are still responsible for payment as you are seen and treated.* If you have any questions, please ask Jean and she will help you with your particular situation.

Please indicate how you are paying for today's charges: _____ check _____ cash

_____ debit/credit card

Signature _____ Date _____