Whole Family Chiropractic
160 NE Maynard Rd, Suite 204 Cary, NC 27513

Personal Data:

Patient Name____________________ Date of Birth__________ E-Mail________________

Address____________________________ City____________ State______ Zip________

SS#______________ Home #______________ Work #______________ Cell #______________

Employer________________ Address____________________________ Zip________

Spouse________________ DOB________ SS#______________ # of Children__________

Spouse's Employer________________ Address____________________ Zip________

Nearest Relative Not Living With You____________________________ Phone____________

Who may we thank for referring you?________________________

Purpose of this Appointment? List Your Complaints. ________________________________

____

What makes the condition(s) better or worse? ________________________________

____

Date of Illness/Injury __________ Where did it occur? ____________________

Is Injury/Illness Related to ___ Auto Accident ___ On the Job ___ Other (explain) ________________

Who is responsible for payment? ___ Self ___ Spouse ___ Other (resp. party) ____________________

Patient's Insurance	**Spouse's Insurance**
Name of Co.________________________	Name of Co. ________________________
Address ________________________	Address ________________________
City, State, Zip ________________________	City, State, Zip ________________________
ID & Group # ________________________	ID & Group # ________________________
Phone # ________________________	Phone # ________________________

Insurance Information

I understand and agree that health and accident insurance policies are an agreement between an insurance carrier and me. I understand that Whole Family Chiropractic will prepare all necessary reports and forms to assist me in making collection from the insurance company and that ay amount authorized to be paid directly to this office will be credited to my account upon receipt. However, I clearly understand and agree that all services rendered to 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 to me will be immediately due and payable. There is a 1-1/2% service charge plus any reasonable collection fees on any unpaid balance.

Consent of Professional Services and Release of Information

I hereby authorize Dr. Bell and whomever she may designate as their assistants to administer treatment, physical examinations, x-ray studies, laboratory procedures, chiropractic procedures and any other services that they deem necessary in my case. I further authorize Dr. Bell to disclose all or any part of my patient record to any person or corporation which is or may be liable under a contract to me or to the patient or to a family member or employer of the patient for all or part of the clinic's charge, including and not limited to, hospital or medical companies, insurance companies, worker's compensation carriers, welfare funds or the patient's employer.

Privacy Notice

I acknowledge that I have received a copy of Whole Family Chiropractic's privacy notice. Initials:________________ Date:__________

Patient Signature____________________ **Parent/Guardian Signature**____________________

Witness Signature____________________

Whole Family Chiropractic

Patient Name ______________________________ Date ______________

Are You ___ Overweight ___ Under Weight ___ Average

Exercise ___ Not Really ___ Sometimes ___ Regularly What type? ______________________

Smoke or chew tobacco? ___ Yes ___ No

Do you drink less than 6 glasses of water daily? ___ Yes ___ No How much? ________

Are you commonly fatigued or tired? ___ Yes ___ No Explain ______________________

Circulatory Problems? ___ Yes ___ No Explain ______________________

Skin conditions? ___ Yes ___ No Explain ______________________

Allergies/Asthma? ___ Yes ___ No Explain ______________________

Do you get sick easily or often? ___ Yes ___ No Explain ______________________

Sinus problems? ___ Yes ___ No Explain ______________________

Do you get headaches? ___ Yes ___ No How often? ____________ Where? ____________

Digestive problems? ___ Yes ___ No Describe ______________________

What is the age of your mattress? ____________ In what position do you sleep? ____________

How many hours of sleep do you get each night? ____________

Please list all of the medications/vitamins you are currently taking: ______________________

____

Would you like to learn more about: ___ Overall health ___ Prevention ___ Lifestyle Changes

What have you done to maintain your spine and nervous system? ______________________

Do you have regular dental check-ups? ___ Yes ___ No

Do you have the oil in your car changed regularly? ___ Yes ___ No

Please list any major stress factors (traumas, work, chemicals, family): ______________________

Please list the major health problems of your immediate family, including children:

Name	**Relationship**	**Age**	**Health Problem(s)**

Please mark your area(s) of pain on the right and describe below:

____

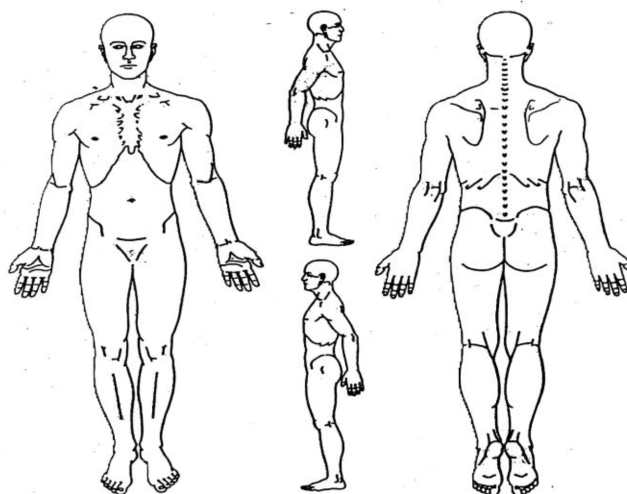
____

____

____

____

____



Signature ______________________________

WELCOME TO WHOLE FAMILY CHRIPOPRACTIC!
WE BELIEVE THAT A CLEAR EXPLANATION OF OUR OFFICE POLICIES WILL ALLOW US TO CONCENTRATE ON THE MAIN GOAL OF REGAINING AND MAINTAINING YOUR HEALTH.

APPOINTMENT POLICY

- The doctors will recommend a care plan designed for maximum results with your condition. If you are unable to keep an appointment for any reason, we ask that you call ahead to reschedule for a later appointment that day or as soon as possible. We respectfully request **24 hours notice** of all cancellations and reserve the right to charge for missed appointments.
- We attempt to honor all appointments at the scheduled time. If you are late, we will try to accommodate you with the next opening.
- Please note that ALL massage appointments not cancelled with at least 24 hours' notice will have a missed appointment charge (1 hour massages $70 and ½ hour massages $40). Missed massage appointments cannot be billed to insurance carriers.
- Patients are responsible for their appointment times; we provide confirmation phone calls and emails as a courtesy.

FINANCIAL POLICY

- It is our policy that all services rendered are charged directly to you- the patient and that you are responsible for all your payments regardless of whether or not this office accepts insurance assignments.
- Deductibles and all co-payments are expected at the time of service or at the end of the week unless other arrangements have been made.
- We reserve the right to add a service charge of 1½ percent monthly to all late and/or overdue accounts.

INSURANCE POLICY

- It is the policy of this office to extend our patients the courtesy of allowing you to assign your insurance benefits directly to us. This policy reduces your out of pocket expense and allows you to place your family under chiropractic care.
- Insurance assignment begins once we receive your signed insurance forms.
- Occasionally, we may experience difficulty in collecting from your insurance company. If this occurs, you may be asked to participate in the collection process. If a problem arises that cannot be resolved, we will expect payment from you and assignment will be terminated.

***As a courtesy to our other patients and staff we ask that you please refrain from any cell phone conversations in our office.**

IT IS OUR GOAL TO PROVIDE YOU WITH THE FINEST QUALITY CHIROPRACTIC CARE AVAILABLE. IF YOU HAVE ANY QUESTIONS WITH REGARDS TO YOUR HEALTH CARE OR ANY OF OUR POLICIES, PLEASE LET US KNOW. WE WELCOME YOUR REFERRALS AND LOOK FORWARD TO A WONDERFUL DOCTOR-PATIENT RELATIONSHIP.

Patient Name (Printed): ____

Patient Name (Signed): ____

Date__________________