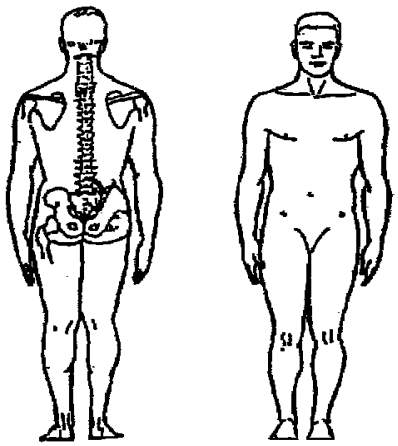
**LaGrange Clinic of Chiropractic**
**INFORMATION/APPLICATION FOR CARE**

The following information is needed in order to better serve you. Please complete all questions. If you need help please ask the receptionist. (PLEASE PRINT.)

Today's Date _____
Name _____ Home Phone _____ Work Phone _____
Cell Phone _____ E-Mail Address _____
Address _____ City _____ State _____ Zip _____
Age _____ Birth date _____ Marital Status: S M W D Number of Children _____

Please circle one payment type: Cash Check Master Card/Visa American Express
Your Employer _____ Occupation _____ Years On Job ____
Employer Address _____ City _____ State _____ Zip _____
Insurance Company _____ Your Social Security # _____
Do you have Medicare? Yes ____ No ____
Name of Spouse or Parent _____ Their Birthdate _____
Spouse Employed By _____ Occupation _____Years On Job ____
Employer Address _____ City _____ State _____ Zip _____
Office Phone # _____ Spouse's SS# _____ Driver's License # _____
Does your spouse have health insurance at work? Yes ___ No ___ Spouse DOB (insurance purposes)_____



**COMPLETE THESE DIAGRAMS**

If you are in pain, please mark the exact location of your pain on the diagram. Also describe the type and frequency of your pain, as well as any activity which brings on or aggravates the pain. For example; dull, sharp, consistent, off & on, when standing, when sitting, etc……

**MAJOR COMPLAINTS**

(Please list any condition you are being treated for or are experiencing.)

_____
_____
_____
_____

Is your condition due to an accident? Yes _____ No _____
Date of accident? _____
Type of accident? Auto _____ Work/On Job _____ At Home _____ Other _____
Have you ever been in an auto accident? Past Year ____ Past 5 Years ____ Over 5 Years ____ Never ____

I (we) agree to pay for services rendered to the above mentioned patient as the charge is incurred. I understand and agree that health & accident insurance policies are an arrangement between an insurance carrier and myself and that I am personally responsible for payment of any and all services covered or not covered. I also understand that if I suspend or terminate my care and treatment, any fee for professional services rendered me will be immediately due and payable.

Patient's Signature _____ Date _____
Or Guardian Signature _____ Date _____

Notice to our new patients: Full payment for services rendered is due at the end of each visit. If for any reason this request cannot be met, arrangements should be made in advance before seeing the doctor.
Insurance cases: On all insurance assignments, the deductible should be met in the beginning unless prior arrangements are made.

In Case of Emergency: ( Name of relative or close friend not living in your home):

Name_____ Address_____
Phone_____