WILLIS CHIROPRACTIC CENTER
APPLICATION FOR CHIROPRACTIC HEALTHCARE SERVICES

Name: _____ S.S.#: _____

Referred by: _____ Home Phone: _____

Address: _____ City, State, Zip: _____

Cell Phone: _____ Date of Birth: _____ Age: _____

Sex: Male / Female Marital Status: _____ No. of children: _____ e-mail add: _____

Occupation: _____ Employer: _____ Work Phone: _____

Spouse's Name: _____ Date of Birth: _____ Cell Phone: _____

Occupation: _____ Employer: _____ Work Phone: _____

HAVE YOU EVER BEEN TO CHIROPRACTOR BEFORE? Yes ____ No ____ Date of last adjustment: _____

Name of Doctor of Chiropractic: _____ Length of time under his/her care: _____

For what condition did you see this doctor? _____

Approximate date of last spinal X-ray study: _____ If female, are you pregnant? Yes ____ No ____

MAJOR COMPLAINTS AND SYMPTOMS: _____

_____

_____

When did you first notice this? _____

Was it caused by: Strain ____ Fall ____ Accident ____ Emotional Stress ____ Other ____

Please describe: _____

_____

IF YOUR PROBLEM WAS CAUSED BY A RECENT AUTOMOBILE ACCIDENT OR AN "ON THE JOB" INJURY, PLEASE GIVE DATE, PLACE AND A BRIEF DESCRIPTION OF THE ACCIDENT. _____

_____

_____

Have you been treated by another doctor for this? Yes ____ No ____ If so, when? _____

List any operations, surgeries or hospitalizations: _____

_____

_____

List any medication you are taking now or have taken in the past 30 days:

_____ how much/frequency: _____ for how long: _____

_____ how much/frequency: _____ for how long: _____

_____ how much/frequency: _____ for how long: _____

Do you have any type of major medical insurance? Yes ____ No ____

Name of Insurance Company: _____

Address to mail claims: _____

Policy #: _____ Group #: _____

Are you covered under any other group or individual health care policy through yourself or your spouse? Yes ____ No ____

X-RAY STUDIES

It is understood and agreed that the amount paid Willis Chiropractic Center for X-Ray studies is for examination only and the x-Ray negatives will remain the property of this clinic, being on file where they may be seen at any time while a patient of this clinic.

SIGNATURE OF APPLICANT: _____ **DATE:** _____

AUTHORIZATION TO PAY PHYSICIAN

I hereby authorize the _____ Insurance Company to pay by check made out and mailed directly to:

Willis Chiropractic Center
Dr. Gary L. Willis
317 N. Main Street
Alpharetta, Georgia 30009

All medical and surgical expense benefits allowable, and otherwise payable to me under my current insurance policy, shall be applied as payment toward the total charges for Professional Services Rendered. This payment will not exceed my indebtedness to above mentioned assignee and I have agreed to pay, in a current manner, any balance of said Professional Services charges over and above this insurance payment.

SIGNATURE OF APPLICANT: _____ **DATE:** _____

SERVICES RENDERED

I understand and agree that health and accident insurance policies are an agreement between an insurance carrier and me. However, I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment.

SIGNATURE OF APPLICANT: _____ **DATE:** _____