THE HEALING TOUCH CHIROPRACTIC

Lawson Chiropractic Corporation

Application For Care

Welcome to our Office!
This information will help us serve you better. Thank you for trusting us with your health.

Name:	**Date:**
Address:	Home Phone:
City/State/Zip:	Work Phone:
Social Security #:	Cell Phone:
Birth Date:	Email:
Driver's License #:	Age: Height: Weight:
Employer:	Occupation:
How do you identify yourself? MALE FEMALE	Marital Status: M W D S DP
Spouse's Name:	Spouse's Occupation:
Children's Names & Ages:	
Patient's Nearest Relative:	Relative's Phone:

Who may we thank for referring you?

Favorite hobbies/sports/interests?

Purpose of this visit? (Please describe your condition, concerns, all health related issues)

Major fall or accident date? (Any major life trauma, current and past)

What do you believe is wrong?

Date present condition began? Please explain.

Have you had previous Chiropractic Care? YES NO Who:

Have you had these complaints before? _____ If so when?

Is this the result of an Auto or Work Injury? _____ If so describe:

Previous Surgeries:

Current Medications:

Have you ever had cancer? YES NO Please describe diagnosis and treatment:

The above information is true and accurate to the best of my knowledge.

Patient Signature: _____ Date: _____

Dr. Darrick Lawson
Dr. Justin Kamerman
Dr. Daniel Miller
The Healing Touch Chiropractic
1919 21st Street, Suite 101 ● Sacramento, CA 95811 ● Ph: 916.447.3344 Fax: 916.447.3388
www.FixMyBack.com

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Payment Policy:

I understand that payment is required at the time of service. Some medical insurance and credit cards are accepted. I understand and agree that health accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that the chiropractic office may prepare billing forms to assist me in making collections from my insurance company. I also give this office power of attorney to endorse checks made out to me, to be credited to my account. 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 terminate or suspend my care and treatment, any fees for professional services rendered to me will be immediately due and payable. I further agree to pay all collections agency fees and other related costs incurred in collection of my account.

I authorize the release of medical records to the physician to whom I may be referred. I authorize the release of any medical information necessary to process insurance claims. On a separate sheet I acknowledge that I have been informed of my rights under HIPAA.

Do you have health insurance? YES NO Company: _____
(Provide us with a copy of your insurance card)

Patient Signature: _____ Date: _____

Pregnancy Release:

Is there any chance you are pregnant? YES NO

Date of last menstrual cycle: _____

This is to certify that to the best of my knowledge I am not pregnant and the above doctor and his/her associates have my permission to perform an x-ray evaluation. I have been advised that x-ray can be hazardous to an unborn child.

Patient Signature: _____ Date: _____

Authorization to Treat a Minor:

Minor Patient Name (please print): _____

Parent or Guardian Name (please print): _____

Relationship of Parent or Guardian: _____

I give authorization to treat the above listed minor patient.

Parent or Guardian Signature: _____ Date: _____

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