# PATIENT INFORMATION UPDATE

**IN ORDER TO BEST SERVE YOU, WE MUST, NATURALLY, HAVE ALL AVAILABLE INFORMATION REGARDING YOUR PRESENT HEALTH. TO BRING OUR ORIGIONAL CASE HISTORY UP TO DATE, PLEASE PROVIDE US WITH THE FOLLOWING:**

**No**:_____ **Date:** _____

**Patient Information**

Patient:_____Date of Birth:_____
Home Address:_____City:_____State:____Zip:_____
Social Security No:_____Home Phone:_____Work Phone:_____
Employer: _____Address: _____
Name of Spouse: _____SS No:_____No. of Children:_____
Spouse's Employer:_____Address: _____
How did you learn of Bey Lea Chiropractic? _____
Nearest relative not living with you?_____Phone:_____
Who is responsible for payment? □Self □ Spouse □ Other _____

| **Patient's Insurance** | **Spouse's Insurance** |
|---|---|
| Name of Company:_____ | Name of Company: _____ |
| Address: _____ | Address: _____ |
| ID & Group No. _____ | ID & Group No._____ |
| Phone No._____ | Phone No.:_____ |

**Purpose of this appointment and list your complaints:** _____
_____ _____
Date of Illness:_____ Time: □ AM □ PM Location: _____
How did accident occur? □ Auto □ On the job □ Other_____
Please describe the circumstances and what makes the condition(s) better or worse:
_____
_____
_____
Other Doctor seen for this condition: _____
Have you been treated by a Doctor for any health condition in the last year? □ Yes □ No
If yes, please describe: _____

**Insurance Information, and Payment Agreement**

I understand and agree that health and accident insurance policies are an agreement between and insurance carrier and myself. Furthermore, I understand that this Chiropractic Office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to this Chiropractic 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.

**Signature Physician:** _____**Signature Patient**:_____

**Consent of Professional Services and Release of Information**

I hereby authorize and release the doctor and whom ever he/she may designate as his/her assistants to administer treatment, physical examination, X-Ray studies, laboratory procedures, chiropractic care or any clinic services that he/she deems necessary in my care; and I further authorize him/her to disclose all or any part of my (patient's) record to any person or corporation which is or may be liable under a contract to clinic or to the patient or to a family member or employer of the patient for all or part of the clinic's charges, including, and not limited to, hospital or medical services companies, workers compensation carriers, welfare funds, or the patient's employer.

Patient's Signature:_____

Parent or Guardian's Signature: _____