

PATIENT INFORMATION

Date: _____
Name: _____
 Last First MI
Address: _____

Sex: M____ F____ Age _____
Birthdate: _____
Single____ Married____ Widowed____ Divorced____
SSN: _____
Occupation: _____
Employer: _____
Employer Address: _____

Spouse's Name: _____
Whom may we thank for referring you?

PHONE NUMBERS

Home: _____
Work: _____
Mobile/Cell: _____
Email Address: _____

PATIENT CONDITION

Reason for visit: _____

When did symptoms appear? _____
Is this condition getting worse? Yes____ No____ Unknown____
Mark an X on the picture to the right where you continue to have pain etc.
Rate the severity of your pain on a scale from 1 (least pain) to 10 (severe pain): _____
Type of pain: Sharp____ Dull____ Throbbing____ Numbness____ Aching____
Shooting____ Burning____ Tingling____ Cramps____ Stiffness____ Swelling____
How often do you have this pain? _____
Is it constant or does it come and go? _____
Does it interfere w/your: Work____ Sleep____ Daily Routine____
Recreation____ Other____
Activities or movements that are painful to perform: Sitting____ Walking____
Standing____ Bending____ Lying Down____ Other____

INSURANCE

Who is responsible for this account? _____
Relationship to Patient: _____
Insurance Co. _____
Insurance ID #: _____
Group # _____

Is patient covered by a 2nd insurance? Yes____ No____
Cardholder's Name _____
Birthdate _____ SSN _____
Relationship to Patient _____
Insurance Co. _____
Group # _____

Assignment and Release

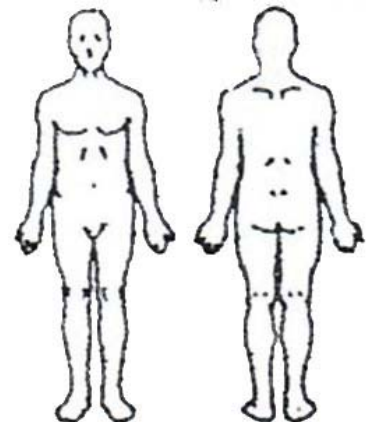
I, the undersigned certify that I (or my dependent) have insurance coverage with _____ and assign directly to Dr. Shawn P. Bradley, D.C. all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether paid or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Responsible Party Signature

Relationship _____ Date _____

ACCIDENT INFORMATION

Is this condition due to an accident? Yes____ No____
Type of Accident: Auto____ Work____ Home____ Other____
Claim Number (if applicable): _____
Date of Accident: _____



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