810 E. Main St., Richmond, MO 64085
(816)776-3302

APPLICATION FOR TREATMENT

Date _____ How did you hear about Jordan-Dunivent Chiropractic?_____

Name_____ Social Security # _____Age _____ DOB_____
Address _____ City _____ State _____ Zip Code_____ Home Phone Number _____ Phone at Work _____ Cell Phone_____ E-Mail Address _____
Check if you are: Married____ Single____ Widowed____ Divorced____ Separated____
Employer _____ Occupation _____
Please describe the principal health problems for which you came to this office. _____
_____
_____
_____
How and when did symptoms first occur? _____
Family Medical Doctor _____
List any other doctors seen for these problems _____
When doctors work together it benefits you. May we have your permission to update your medical doctor regarding your care at this office? Yes____ No____ Address _____
List diagnosis(es) and type of treatment(s) _____
_____
_____
Does this interfere with your normal living and work? Yes____ No____ In what way? _____
Have you lost any days of work? Yes____ No____ Dates _____
Have you had similar symptoms or injuries before? Yes____ No____ If yes, explain _____
_____
List the names of any relatives that have or have had a similar problem _____
_____
Who to contact in case of an emergency? _____

PAST HISTORY

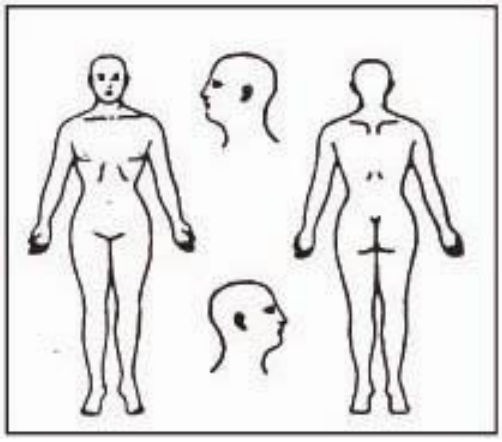
Has a physician treated you for any health condition in the last year? Yes____ No____
If yes, explain: _____
_____
Have you or any relative received Chiropractic treatment previously? Yes____ No____ If yes, explain _____
_____
Do you have a history of stroke or hypertension?_____ Do you smoke? Yes No If Yes, how much per day?_____
List the approximate dates of any operations, unusual diseases, serious illnesses or accidents you have had (include any broken bones)
_____
_____

List all drugs or medication that you have used recently (i.e., aspirin, sleeping pills, birth control pills, etc.
_____
How many days a week do you exercise? [ ]none [ ]1-2 [ ]3-4 [ ]5-7
Are you, or do you think, you might be pregnant? Yes____ No____

FAMILY HISTORY

Name of wife or husband _____ Ages of children _____
Spouse's Employer _____ Business Phone _____
Your Nearest Relative _____
Relative's Address _____

Please mark your areas of pain on the figures below.



List the conditions that you are most interested in getting corrected. List in order of importance:

1. _____
2. _____
3. _____
4. _____

What functions are you unable to perform or induce pain upon performance? List in order of severity. (Example: sitting, walking, bending, lying down, etc.)

1. _____
2. _____
3._____
4. _____

Who is responsible for your bill? Self ____ Spouse____ Employer____

Please check any and all insurance coverage that may be applicable in this case:
[ ] Health Insurance [ ] Worker's Compensation [ ] Medicaid [ ] Automobile Ins. Policy
[ ] Medical Savings Account & Flex Plans [ ] Other

Name of Primary Insurance Company:_____

Name of Secondary Insurance Company:_____

AUTHORIZATION AND RELEASE: I authorize payment of insurance benefits directly to the chiropractor or chiropractic office. I authorize the doctor to release all information necessary to communicate with personal physicians and other healthcare providers and payors and to secure the payment of benefits. I understand that I am responsible for all costs of chiropractic care, regardless of insurance coverage. I also understand that if I suspend or terminate my schedule of care as determined by my treating doctor, any fees for professional services will be immediately due to and payable. Fees are payable at the time of examinations and treatments are received unless other arrangements are made in advanced.

The patient understands and agrees to allow this chiropractic office to use their Patient Health Information for the purpose of treatment, payment, healthcare operations, and coordination of care. We want you to know how your Patient Health Information is going to be used in this office and your rights concerning those records. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your Patient Health Information we encourage you to read the HIPAA NOTICE that is available to you at the front desk before signing this consent. If there is anyone you do not want to receive your medical records, please inform our office.

Patient's Signature:_____ Date:_____

Guardian's Signature Authorizing Care:_____ Date:_____