New Patient Form

Name: _____SS#:_____ Date of birth_____

Address: _____ City: _____ State: _____ Zip:_____

Home Phone: _____ Cell Phone: _____Work Phone: _____

Email address: _____@ _____ Fax Number: _____

Employed with: _____ HR Director Name:_____
HR PH:_____ Spouse Name: _____

Emergency Contact: _____ Phone: _____

You Were Referred By: (Friend) (Relative) (Internet Search) (Mailer) (Sign) (Other _____)

Which one of our patient's should we thank for referring you? _____

Please circle your current symptoms:

(Neck Pain) (Headaches/Migraines) (Neck Stiffness) (Allergies) (Shoulder/Arm Pain)
(Upper-Back Pain) (Mid-Back Pain) (Low-Back Pain) (Hip/Pelvis Pain)
(Asthma) (Stomach Pain) (Chest Pain) (Numbness) (Arthritis) (Sciatica)
(SinusProblems) (Other_____)

My Medical Doctor: _____ Medical Doctor Clinic Name: _____
Do we have permission to send perodic reports to them? Y or N

My symptoms are related to: (Auto Accident) (Work Accident) (Home Accident) (Gradual Onset)

List all surgeries in the past 5 years: _____

Have you ever had spinal surgery? No Yes: _____

List any serious condition the doctor should be aware of: _____

Previous Chiropractor/PT/Massage Therapist: _____

Were you satisfied? Yes No _____

***Females: Are you pregnant at this time? No Yes Due Date: _____**

Office Policies: ***If I am accepted as a patient into the Byers Chiropractic & Massage Kent clinic, I agree to pay for all services including services not covered by my insurance company. If I suspend (or terminate) my treatment without the doctor's agreement, it will be understood that I have reached maximum healing for my injury or condition. I then agree to be fully responsible for my condition and future care. I understand that no medical records or x-rays will be released from this office if I owe any money on my account. If at any point I request a refund for unused payments made, I understand this process may take up to 30 days.***

Insurance: ***We accept most insurance company plans and most often we have checked on your insurance before your initial visit with us and we will inform you of any payments due. If an incident report is needed to process my insurance, I authorize Byers Chiropractic & Massage to complete one using only the information collected within my confidential patient file. In the event your insurance company does not pay your quoted benefits, I authorize Byers Chiropractic & Massage to file a formal complaint to the insurance commissioner on my behalf. If an insurance complaint does not resolve my balance, the balance is due by me. I also understand if I request a refund; no refund will be issued until the insurance has paid on all dates of service for which care was rendered. This may take up to 30 days.***

Consent To Treat: ***I also understand that no cures are promised (or implied) and any risks regarding care at this office will be explained to me upon request. I now authorize the attending Dr to proceed with any necessary treatment. I have read Byers Chiropractic & Massage policies and consent to treatment information, and I agree with them by signing below. I authorize Byers Chiropractic & Massage to contact my medical doctor in regards to my condition I am being seen for.***

Consent To Treat a Minor Child: by signing below I authorize treatment of my minor child to be rendered by Byers Chiropractic and Massage and their health care providers.

Patient or Guardian Signature: _____ Date: _____