

SANTA CLARA CHIROPRACTIC CENTER

PERSONAL HISTORY

Name: _____ Age: _____ Date Of Birth: _____
Driver's License #: _____ Social Security#: _____ Sex: M F
Address: _____ City: _____ State: _____ Zip: _____
Home Phone: _____ Cell Phone: _____ E-Mail: _____
Marital Status: Married Single Divorced Widowed
Employer/Occupation: _____ Work Phone: _____
Emergency Contact Name, Phone, and Relationship: _____
Spouse's Name: _____ Spouse's Employer/Occupation: _____
Spouse's Work Phone: _____ Spouse's Social Security#: _____
How were you referred to our office? Google Yahoo Yelp Friend/Relative Other: _____

INSURANCE INFORMATION

AUTO WORK COMP PRIVATE INS MEDICARE CASH PAY
Insurance Company: _____ Insurance Phone: _____
Billing Address: _____ City: _____ State: _____ Zip: _____
Insured Name: _____ Insured DOB: _____ Insured's ID and/or SSN: _____
Spouse's Insurance Co: _____ Insurance Phone: _____

CURRENT HEALTH CONDITION

Is this condition: Job Related Auto Accident Sports Injury Chronic Other _____
Last Day Worked: _____ if related to an accident, please provide details: _____

Purpose of this appointment: _____

List any other doctors visited for this condition: _____

List any diagnosis and type of treatment received: _____

Have you had similar accidents or injuries in the past? Yes No, if yes, please explain _____

Have any of your relatives had a similar problem? Yes No

Have you received any Chiropractic Treatment recently? Yes No, if yes please explain _____

Have you been treated for any health condition by a physician within the last year? Yes No, if yes please explain _____

Are you currently taking any medication? Yes No, if yes please list medications and the conditions you're taking medications for: _____

Have you taken any medication in the past? Yes No, if yes please list medications: _____

List the dates for past injuries and conditions you've received treatments for: _____

Family History, Health Conditions, Age and cause of death:

Father: _____

Mother: _____

Brothers and/or Sisters: _____

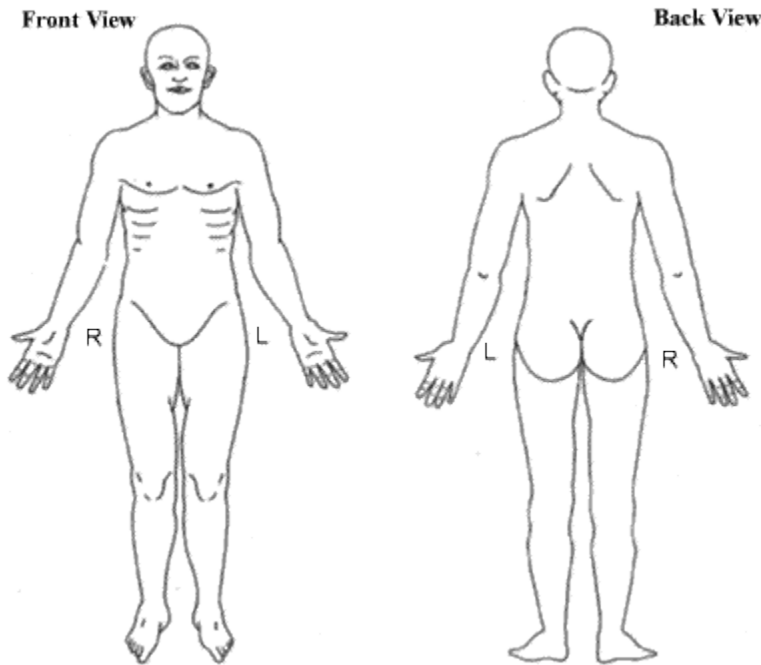
Do you smoke? Yes No How many caffeinated drinks per day you drink? _____

Do you drink Alcohol? Yes No, if yes is it Daily Weekly Social Occasions

Do you take Vitamins / Supplements? Yes No, if yes please specify the type and frequency of consumption:

Please circle degree of pain you're experiencing, with 0 being no pain and 10 for severe pain:
Using the symbols below, mark on the diagrams where you feel the pain.

Numbness	===
Dull Ache	OOO
Burning	XXX
Sharp/Stabbing	///
Pins, Needles	+++
Other _____	^^^



PATIENT FINANCIAL POLICY

In order to receive the best care possible within your maximum benefits, it is important that you comply with our financial policy:

1. **Payment is expected at the time of service** in the form of a deductible, copayment, or coinsurance payment. **It is illegal to waive these fees.**
2. Your policy is a contract between you and the insurance company and you are responsible for any unpaid or denied claim, and for any collection fees, court costs, and attorney's fees if your account is turned over for collection.
3. If your insurance company sends you checks, it is your responsibility to deliver them to our office within 5 (five) days.
4. Affordable payment plans or hardship forms are available in special cases.
5. **Cancellations** must be made with **12 hours' notice** or you will be charged for an office visit on the third occurrence.

I hereby authorize Santa Clara Chiropractic Center to furnish information to my insurance company concerning my care. I further hereby assign to Santa Clara Chiropractic Center all insurance payments for chiropractic services rendered to me, or my dependents, by Dr. Bella Delyaei. I have read and understood the above statements.

Signed _____
Patient or responsible party

Date _____