**New Patient Paperwork**

**Today’s Date \_\_\_\_\_\_\_\_\_\_\_\_ Date of Injury \_\_\_\_\_\_\_\_\_\_\_**

**Last Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ First Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Date of Birth \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Mailing Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Physical Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**City \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State \_\_\_\_\_\_\_\_ Zip Code \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Email Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Cell Phone # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

 **Cell Phone Carrier (for appt reminders) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Regarding your main complaint:

* Right now: 0 1 2 3 4 5 6 7 8 9 10
* Average: 0 1 2 3 4 5 6 7 8 9 10
* At worst: 0 1 2 3 4 5 6 7 8 9 10

|  |  |
| --- | --- |
| S |  Stabbing |
| B | Burning |
| N | Numbness |
| P | Pins and Needles |
| A | Aching |

Please illustrate areas of complaint on the picture below. Please mark using the symbols listed in the key. 

**INSURANCE INFORMATION**

**Primary Insurance \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Subscriber Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Subscriber ID # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Group # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Secondary Insurance \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Subscriber Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**FINANCIAL AGREEMENT**

* New Patient Fee is $210.00
* Medical Insurance is billed as a COURTESY to our patients
* Patients are responsible for any charges incurred regardless of insurance coverage
* A 24 hour notice is required to cancel or change any appointments
* $60 will be charged for missed appointments

**I authorize Dr. Amy Vevoda to administer treatment and understand the financial agreement.**

**Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**(Please provide your insurance card and driver’s license to make copies for your file.)**

**CONSENT TO TREAT A MINOR**

**I (we) being the parent, guardian or custodian of the minor being \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, age \_\_\_\_\_\_\_\_, do hereby authorize, request & direct Incline Chiropractic, its doctors and staff to perform examinations, diagnostic x-rays, laboratory tests, and any treatment that in their judgment, is deemed advisable or required. It is the understanding of the undersigned that the physicians and their staff will have full authority from me as legal parent/guardian to continue with examinations, diagnostic tests, and treatments as will be needed while said minor shown above is under care in this office until legal age is attained. As legal parent/guardian, I realize full responsibility for all charges and payments due.**

**Parent/Guardian or Custodian Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date Signed \_\_\_\_\_\_\_\_\_**

**Witness \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**