FRISCO CHIROPRACTIC CENTER

TEXAS DRIVERS LICENSE # _____

NAME: _____ DATE: _____
(first) (middle) (maiden) (last)

HOME ADDRESS: _____ BIRTH DATE: _____
(street) (city) (state) (zipcode)

REFERRED BY:_____ HOME PHONE: _____

MOBILE PHONE_____ EMAIL : _____

EMPLOYER: _____ OCCUPATION: _____

NAME OF SPOUSE: _____ SPOUSE WORK PHONE: _____

NEAREST RELATIVE NOT LIVING WITH YOU:_____
(full name) (address) (phone)

****

PURPOSE OF THIS APPOINTMENT: _____

HOW LONG HAVE YOU HAD THIS PROBLEM?_____

DATE OF ACCIDENT / ONSET: _____ TIME: _____am\ pm **LOCATION:_____**

HOW DID ACCIDENT OCCUR? AUTO ON THE JOB OTHER:_____

PLEASE DESCRIBE THE CIRCUMSTANCES:_____

_____

HAVE YOU LOST TIME FROM WORK? YES NO DATES: _____
(from) (to)

HAVE YOU SEEN ANOTHER DOCTOR FOR THIS PROBLEM? YES NO NAME/SPECIALTY:_____

PREVIOUS ACCIDENTS: _____

PRIOR SURGERIES: _____

MEDICATIONS: _____

NAME / LOCATION OF PREVIOUS CHIROPRACTOR: _____ TREATED FOR: _____

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READ AND SIGN BELOW

WE ARE HAPPY TO FILE ANY APPLICABLE INSURANCE FOR YOU HOWEVER EVERY TYPE OF PLAN MAY HAVE LIMITATIONS IN VISITS ALLOWED OR DOLLAR AMOUNTS COVERED. WE WILL VERIFY YOUR PLAN AND INFORM YOU OF YOUR BENEFITS, BUT SHOULD YOU EXCEED THEM, YOU WILL BE BILLED FOR THE BALANCE. WE WILL NOT ACTIVELY KEEP UP WITH YOUR ONGOING STATUS BUT WILL BE HAPPY TO PROVIDE ANY REQUESTED INFORMATION YOU MAY REQUIRE TO DO SO.

By signing below, I also understand that Frisco Chiropractic Center may release my medical information as requested by my insurance company in order to process my health claims from this office. I also understand that if any other 3rd party entity to whom I have given permission, should request a copy of my medical information from this office, those records will also be provided.

_____ _____
Signature of Patient (or Parent/Guardian if patient is under 18) Date

(Please complete the other side)

Circle all symptoms you are having now
Underline symptoms you have had in the past

General Symptoms

Headaches
Fever
Dizziness
Loss of Sleep
Fatigue
Loss of Weight
Numbness / Tingling
(arms - legs)

Muscle & Joint Symptoms

Neck stiff pain
Mid Back stiff pain
Low Back stiff pain
Muscle Spasms
Tail Bone pain
Rib Pain
Arthritis
Shoulder Pain
Arm / Hand Pain
Leg / Foot Pain

Cardio – Vascular

Rapid Heartbeat
Slow Heartbeat
High Blood Pressure
Low Blood Pressure
Pain over the Heart
Previous Stroke
Hardening of the Arteries
Poor Circulation

Genito – Urinary

Frequent Urination
Painful Urination
Blood in Urine
Kidney Infection or Stones
Bed Wetting
Loss of Urine Control
Prostate Trouble

For Women Only

Painful Menstrual Periods
Excessive Flow
Hot Flashes
Irregular Cycle
Cramps or Backache
Menopausal Symptoms
Are you Pregnant? Yes No

Gastrointestinal

Poor Appetite
Difficult Digestion
Belching or Gas
Nausea
Vomiting
Stomach Pain
Abdomen Distension
Constipation
Diarrhea
Colon Trouble
Gall Bladder Trouble
Liver Trouble
Colitis

Skin

Skin Eruption
Itching
Bruise Easily
Dryness
Sensitive Skin

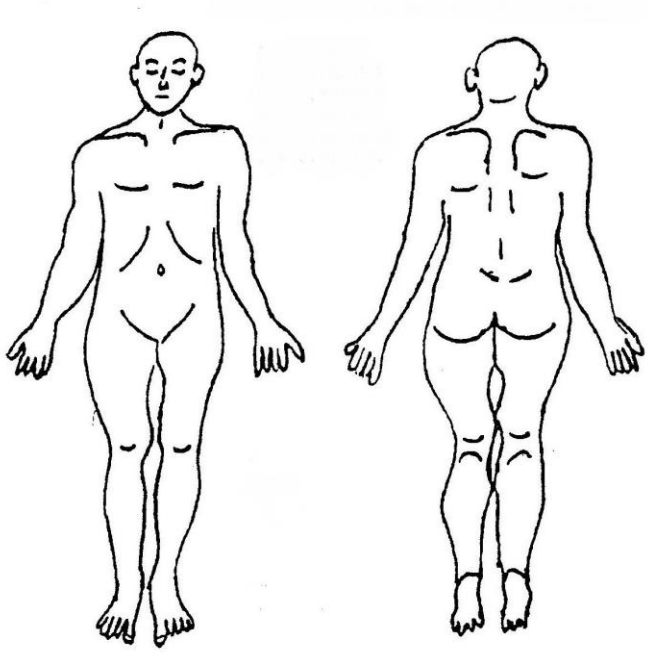
Ears - Eyes - Nose - Throat

Vision Problems
Eye Pain / Strain
Deafness
Earaches
Ear Noises
Nose Bleeds
Nasal Obstruction
Sore Throat
Hoarsness
Frequent Colds / Hay Fever
Enlarged Thyroid
Sinus Infection
Nasal Drainage

Respiratory

Asthma
Chronic Cough
Spitting up Phlegm
Chest Pain
Difficulty Breathing

Symptom Chart
Illustrate your symptoms on the chart



Patient Name _____ Date _____

Signature (guardian if minor) _____

INSURANCE POLICY – FRISCO CHIROPRACTIC CENTER

Frisco Chiropractic Center understands that you are seeking care at our office for health problems you feel require treatment.

We do our best to inform you of your contracted benefits, if applicable, and do our best to file and document your care as presented and preformed. We will also provide your insurance company with any requested additional information, in an attempt to secure reimbursement.

However, your insurance company has criteria included in your contract that may allow them to deny care. This generally relates to care your insurance company feels is unnecessary or is for maintenance only.

I understand that should my insurance company deny coverage for services rendered by the Frisco Chiropractic Center or deem them unnecessary; I will cover these unpaid charges.

PATIENT:_____

PATIENT OR LEGAL GUARDIAN SIGNATURE:_____DATE:_____

CONSENT FOR CHIROPRACTIC TREATMENT – FRISCO CHIROPRACTIC CENTER

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy, massage and diagnostic X-rays, on me (oron the patient named below, for whom I am legally responsible) by Dr. Flint Loughridge DC and/or other licensed doctors of chiropractic who now or in the future work at the clinic.

I have had an opportunity to discuss with the doctor of chiropractic and/or with other office or clinic personnel the nature and purpose of chiropractic adjustments and other procedures. I understand that results are not guaranteed.

I understand and am informed that, as in the practice of medicine, in the practice of chiropractic there are some risks to treatment, including but not limited to fractures, disc injuries, strokes, dislocations and sprains. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely upon the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known to him or her, is in my best interest.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above-named procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

PATIENT:_____

PATIENT OR LEGAL GUARDIAN SIGNATURE:_____DATE:_____