Patient Name _____ Date _____

LUDVIGSON CHIROPRACTIC

Patient History

Are you seeing anyone else for other problems or health conditions? ☐ Yes ☐ No
Please list the problem/s, date problem/s began, and Provider/s treating you for the condition/s:

_____
_____
_____

Past Health History

Have you...
- been hospitalized in the last 5 years? ☐ Yes ☐ No
- been diagnosed with Diabetes? ☐ Yes ☐ No
  Type I _____ Type II _____
- been treated for hypertension? ☐ Yes ☐ No

If yes, include date & provider seen
_____
_____
_____
_____

Do you smoke? ☐ Never ☐ Former Smoker ☐ Current/Every Day Smoker ☐ Current Some Day Smoker

Medications

What medications are you currently taking? Include vitamins, herbs, minerals...
Please be as specific as possible

_____
_____
_____
_____

Allergies

Do you have allergies? ☐ Food ☐ Environmental ☐ Medication
List Type of Allergy and Reaction

_____
_____
_____

Assignment & Release

Insurance Information

I understand and agree that health and accident insurance policies are an agreement between an insurance carrier and myself. Furthermore, I understand that this office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to this doctors office will be credited to my account upon receipt. However, I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees or outstanding balances for servives I have recieved will be immediately due and payable.

Patient's/Parent's/Guardian's Signature:_____

Consent of Professional Services and Release of Information

I hereby authorize and release the doctor and whomever he/she may designate as his/her assistants, to administer treatment, physical examinations, x-ray studies, laboratory procedures, chiropractic care or any clinic services that he/she deems necessary in my case; I furthermore authorize him/her to disclose all or any part of my patient record to any person or corporation which is or may be liable under a contract to this office or to the patient or to a family member or employer of the patient for all or part of the clinic's charge, including, and not limited to hospital or medical service companies, insurance companies, worker's compensation carriers, welfare funds, or the patient's employer.

Patient's/Parent's/Guardian's Signature:_____