PLEASE PRINT

Purpose of this appointment (Major Complaint)____________________

What activities aggravate your condition?____________________

Is this condition getting progressively worse? ❑ Yes ❑ No ❑ Constant ❑ Comes and goes

Is this condition interfering with your: ❑ Work ❑ Sleep ❑ Daily Routine ❑ Other__________

How long has it been since you really felt good?____________________

What do you believe is wrong with you?____________________

Other Doctors seen for this condition____________________

Have you been treated for any health conditions by a physician in the last year ❑ Yes ❑ No

Describe____________________

What medications or drugs are you taking?____________________

Remarks and additional information ____________________

PAYMENT IS EXPECTED AT TIME OF VISIT!

Name of person responsible for payment____________________

Are you insured? ❑ Yes ❑ No Company____________________

I understand that payment is required at time of service. Most medical insurance and some credit cards are accepted. I understand and agree that health accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that this chiropractic office will prepare any necessary reports and forms to assist me in making collections from the insurance company and that any amount authorized to be paid directly to this chiropractic office will be credited to my account on receipt. I also give this office power of attorney to endorse checks made out to me, to be credited to my account. 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 for professional services rendered me will be immediately due and payable. I further agree to pay all collection agency fees, attorney fees, court fees and other related costs incurred in the collection of my account.

I authorize the release of medical records to the physician or physicians to whom I may be referred. I authorize the release of any medical information necessary to process insurance claims.

I authorize payment of medical benefits to Dr. Colin W. Frogley

Patient Signature ____________________ Date __________

Guardian or Spouse's Signature Authorizing Care____________________ Date __________

Information Taken by____________________ Date __________

COMMENTS:____________________