Clear Choice Chiropractic

of Niles, PC

CONFIDENTIAL PATIENT INFORMATION UPDATE

This information is strictly confidential. If we do not sincerely believe that you will respond favorably to chiropractic care we will not accept your case, but will refer you to disciplines we believe will help you. In order for us to understand your health problems properly, please complete this form neatly, accurately, and completely. If you have any questions don't hesitate to ask one of our staff members for help. Thank You.

Date_____ Name _____

Address_____ City_____ State_____ Zip Code _____

Phone _____ Birth date _____ Marital Status: S M W D

If female, are you pregnant? Yes No E-mail address _____

Occupation_____ Employer_____

Work Address _____ Work Phone_____

Have you had any recent surgeries / broken bones / traumas? Yes No _____

List any medications or any diet supplements you are currently taking including over-the- counter drugs _____

ABOUT YOUR CURRENT CONDITION

Reason for contacting our office today _____

When did this condition first begin?_____ Is your condition getting worse? Yes No

Is your present condition the result of any Auto Accident or Work Related Injury? Yes No

How did this condition arise? Please describe_____

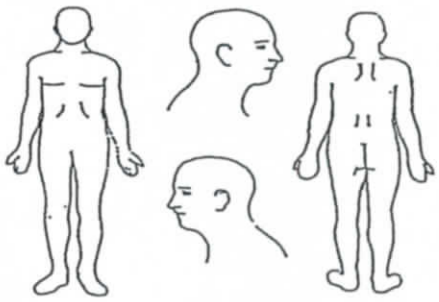
Other doctors consulted for this condition

_____

_____

Has there been any change in your insurance information? Yes No

Please shade in any areas of pain or injury on the figures below.



I here by instruct and direct my insurance company and or attorneys to make payment for services rendered directly to :

Clear Choice Chiropractic

P.O. Box 725 Niles, MI 49120

If my insurance carrier prohibits direct payment to this clinic, then I hereby also instruct and direct my insurance company to make the check out to me and mail it as follows:

Clear Choice Chiropractic

P.O. Box 725 Niles, MI 49120

THIS IS A DIRECT ASSIGNMENT OF MY RIGHT AND BENEFITS UNDER THIS POLICY. This payment will not exceed my indebtedness to the above mentioned assignee and I further agree I will pay, in a current manner, any balance of said professional services charges over and above this insurance payment.

A photocopy of this agreement shall be considered as effective and valid as the original document.

I authorize the release of any information pertinent to my case to all insurance carriers, adjusters or attorneys directly involved with my case.

Signature_____ Date_____ Witness Signature_____ Date_____