

Confidential Patient Information

Chiropractic Spine Center | 1930 Pearl Rd. #2 Brunswick, OH 44212 | Phone (330) 220-2001 FAX (330) 220-2232

Date Age D.O.B. (Mo/Day/Year) Sex Marital Status

First & Last Names E-mail

Street Address Apt# City State Zip Code

Phone () Work Phone () Social Sec #

Occupation Employer Location

Guardian/Spouse's Full Name D.O.B. Social Sec #

Occupation Employer Location

Name, work phone and city of nearest relative (not your spouse):

Were you referred to a certain doctor in this office? Is your visit due to an accident? No Yes

YOUR PRESENT COMPLAINT(S)

List other doctor(s) seen for this condition:

Personal Medical history (if any of the following are relevant to your medical history, please check the accompanying box)

- Checkboxes for various medical conditions: Cancer, Polio, Tuberculosis, Arthritis, Heart Trouble, Diabetes, Muscular Dystrophy, Multiple Sclerosis, Convulsions, Epilepsy, Concussion, Hepatitis, Rheumatic Fever, Scarlet Fever, Nervousness, Asthma, Dizziness, German Measles, Digestive Disorders, Sinus Trouble, Backaches, Numbness, High Blood Pressure, Venereal Disease.

Describe any operations you've had and the dates:

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

Describe Condition Date of last physical exam

Are you now taking any medication? Yes No. What kind?

Are you allergic to any medication? Yes No. What kind?

Are you pregnant? Yes No. Date of last menstrual period:

Do you have insurance? Yes No. Company I.D. No. Policy Group No.

I understand and agree that health and accident insurance policies are an arrangement 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 office will be credited to my account upon receipt. I permit this office to endorse co-issued remittances for the conveyance of credit 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. It is my understanding that my credit may be checked if Chiropractic Spine Center extends credit to me and I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered to me will be immediately due and payable unless prior arrangements are made. I hereby authorize the doctors at Chiropractic Spine Center and whomever they may designate as their assistants to administer treatment as they so deem necessary and I also authorize the release of any information acquired in the course of my examination or treatment. I certify that the above information is true and correct.

Patient's (Parent or Guardian's) Signature

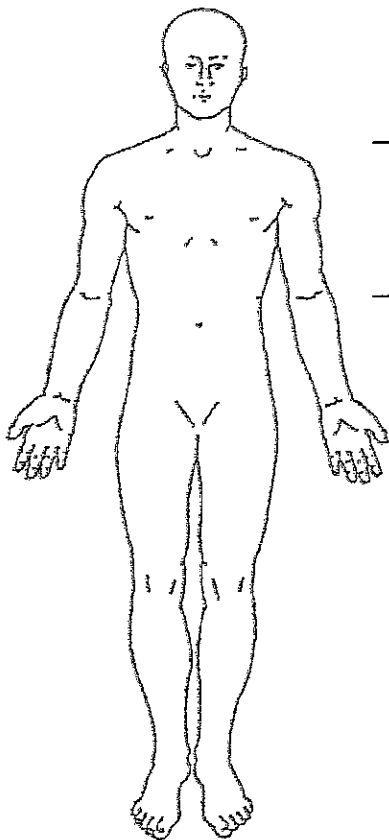
PAIN DIAGRAM

Please read and follow the instructions below. Thank you.

1.) Mark the areas on the diagram where you feel the following sensations:

<u>Numbness</u>	<u>Pins & Needles</u>	<u>Burning</u>	<u>Aching</u>	<u>Stabbing</u>
-----	00000	XXXXXX	*****	/////
-----	00000	XXXXXX	*****	/////
-----	00000	XXXXXX	*****	/////

2.) Indicate the severity of your symptoms by making an "X" on the line:



How bad are your symptoms now?

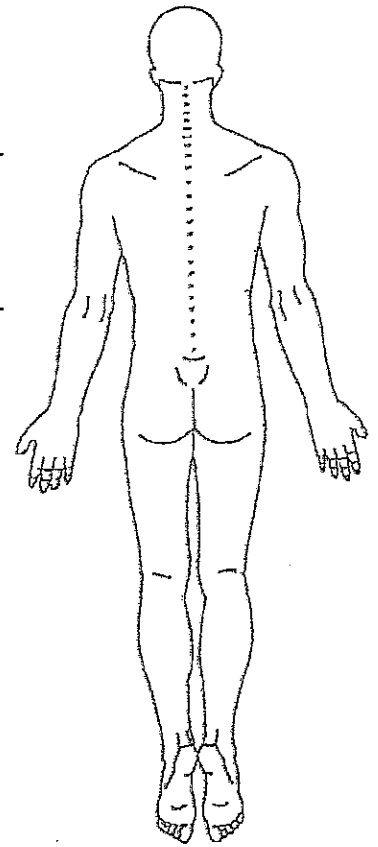
None

Most Severe

How bad have they been in the past?

None

Most Severe



Signature: _____

Date: _____

**PATIENT ACKNOWLEDGEMENT OF
RECEIPT OF NOTICE**

I hereby acknowledge receipt of the Notice of Privacy Practices for **Chiropractic Spine Center, LLC** regarding my health information. I have been informed and understand the manner in which my health information shall be maintained, utilized and disclosed by **Chiropractic Spine Center, LLC** and my respective rights contained there in. I also understand that the Notice furnished to me is subject to change at any time. I am aware that I may obtain a current copy of this Notice at any time by contacting **Dr. Nicholas S. Cambouris, D.C.** at **330-220.2001, 1930 Pearl Road Suite 2A, Brunswick, OH 44212.**

My signature herein below constitutes full acknowledgement that I have furnished a copy of the Notice of Privacy Practices for **Chiropractic Spine Center, LLC.**

Patient Signature

Date

Patient's Legal Representative
if required

Date

If signed by patient's legal representative, please state representative's relationship to patient:

Physician Information Form

Your Name: _____ Date: _____

Primary Care Physician: _____

Physician's Address: _____

City: _____ State: _____ Zip: _____

Physician's Phone Number: (_____) _____

Do you see a Specialist? (i.e. Cardiologist, Neurologist, Nutritionist, ENT, etc)

Yes _____ No _____

If Yes:

Specialist's Name: _____ Specialty: _____

Specialist's Address: _____

City: _____ State: _____ Zip: _____

Specialist's Phone Number: (_____) _____

Specialist's Name: _____ Specialty: _____

Specialist's Address: _____

City: _____ State: _____ Zip: _____

Specialist's Phone Number: (_____) _____

Specialist's Name: _____ Specialty: _____

Specialist's Address: _____

City: _____ State: _____ Zip: _____

Specialist's Phone Number: (_____) _____
