



Welcome To Our Clinic!

Application for Treatment

Date _____
Name _____ Birth Date _____ Age _____
Social Security # _____
Address _____ City _____ State _____ Zip _____
Home Phone _____ Cell Phone _____
Email _____
Your Occupation _____ Employer _____
Work Phone _____
Marital Status M S D W Spouse or Parent/Guardian _____

Whom may we thank for referring you? _____

General Health History

Have you been treated for any health condition by a Physician in the last year? Yes _____ No _____
If yes, explain _____

Have you previously received chiropractic treatment? Yes _____ No _____
If yes, list dates consulted and for what problems:

Are you Pregnant? Yes _____ No _____
Check off the drugs you are taking: Nerve Medication ___ Pain Killers ___ Muscle Relaxers ___
Blood Pressure Medication ___ Insulin ___ Birth Control Pills ___ Tranquilizers ___
Diet Pills ___ Sleeping Pills ___ Antidepressants ___ Other (Please list)

List the approximate dates of any operations, unusual diseases, serious accidents you have had (including any broken bones):

Have you ever been in an automobile accident? Past year _____ Past 5 years _____ Over 5 years _____

Financial Responsibility

Who is responsible for the bill? Self ___ Employer ___ Insurance ___ Other ___
Method of payment you plan to use to cover today's charges? ___ Check ___ Cash ___ MasterCard/Visa

Type of Insurance: Health Insurance _____ Worker Compensation _____ Auto Insurance _____
Insurance Company Name _____

If the insurance policy is in any name other than yourself, please provide name and date of birth if insured:
Name _____ Birth Date _____

Is there any secondary policy that you have health insurance through: Yes _____ No _____
If yes, please provide insurance company's name, address and insured's name, address and date of birth:

Please complete the back side of this application

Consent to Treat a Minor Child:

I hereby authorize Performance Chiropractic/AthletesEDGE to administer chiropractic and/or athletic injury services as deemed necessary to my child.

Patient or Legal Guardian

X-Ray Confirmation:

This is to confirm that I have been informed by this office that x-rays can be hazardous to an unborn child. At this time, to the best of my knowledge, I am not pregnant, and I consent to radiographs for the purpose of diagnosis and treatment.

Notice: Not all patients require x-rays to determine diagnosis, type of treatment or length of treatment. The radiographs taken are for the purpose of analysis and diagnosis. They are property of this office and are a part of your permanent records.

Initial _____

Covenant to Pay Charges and Interest:

I recognize that Performance Chiropractic/AthletesEDGE "PCPC" is not a party to any agreement between my insurance carrier and myself. I recognize PCPC will process the necessary forms and documentation for collection from my insurance provider to an extent reasonable. I recognize that any benefits paid directly to PCPC will be credited to my account upon receipt unless prohibited by law or other contractual arrangement. PCPC is further authorized to endorse my name on any document that contains my name where legally entitled to do so.

I unconditionally recognize and affirm that I am wholly liable for the payment of any expenses or costs resulting from treatment or services incidental thereto rendered by PCPC. I accept and affirm that upon default of payment by me, written notice of default shall be sent by PCPC within 90 day. After 90 days I understand that my account shall be turned over to a third party collection agency or agree that PCPC hold a valid credit card on file for any outstanding expenses or cost over 90 days.

I have read the above terms. I understand and accept the above terms.

Patient or Legal Guardian

Date: _____

Performance Chiropractic, P.C.

Date: _____