lazarspinalcare pc

We listen. We care. We get results.

Confidential Adult Patient

REACTIVATION

Today's date:

Welcome back! Please update your information:

Patient's name: SSN:

Address: DOB:

City, State & Zip:

Home phone: Cell:

Email:

Appointment Reminders (circle one): Email SMS/Text Cell Phone Carrier:

May we leave messages about your care on a voicemail (circle one): YES / NO

Marital Status: Spouse's (or significant other's) Name:

Kids' Names and Ages:

What is your emergecy contact and employment info?

Emergency contact: Phone:

Emergency relation: Your occupation:

Your employer: Phone:

Address:

Do you have a family doctor or dentist?

Family doctor: Phone:

Family dentist: Phone:

Whom may we thank for referring you:

Previous chiropractor: Date:

Do you wear orthotics? YES / NO

Would you like to receive our email newsletter? YES / NO

Terms of agreement

Due to changes in health insurance fees, patient self biling has become a much more cost effective way for you, the patient to get reimbursement for your care. Self biling allows us to keep our fees low so you can get the care you need without any added cost. Therefore, our policy is that all payment is due at the time of service and bills will not be sent to your insurance provider. Statements will be provided for you to submit on your own ensuring that as your insurance provider pays for your care, they will send the reimbursement check directly to you.

Method of payment

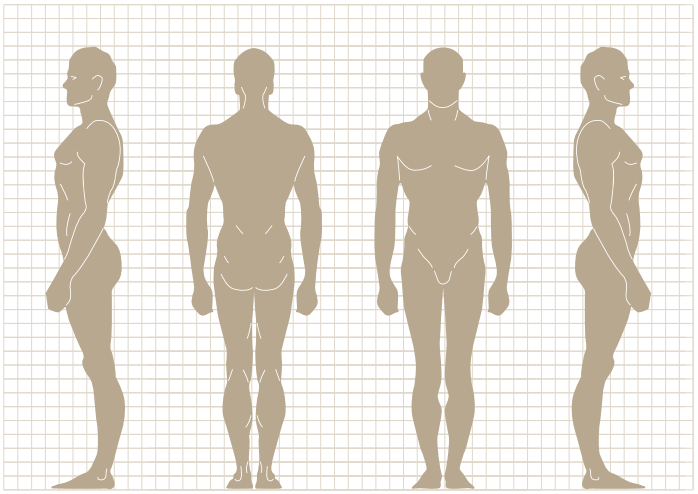
I will be paying with: ☐Cash ☐Check ☐Credit Card ☐Care Credit

Signature of agreement

I authorize Lazar Spinal Care to render necessary services to me and I am responsible for all charges incurred.

Signature: Date:

Where are your problem areas?



What hurts and how long has it hurt?

1.

2.

3.

4.

What Chiropractors or Medical Doctors have you consulted?

1.

2.

3.

4.

What do you think caused these problems?

1.

2.

3.

4.

Do you experience any of these health problems?

☐Headaches	☐Pulled muscles	☐Car accident	☐Sinus pain/allergies
☐Sleeping problems	☐Stressed shoulders	☐Leg & hip pain	☐Scoliosis
☐Emotional stress	☐Wrist or joint pain	☐Neck pain	☐Stiffness
☐Numbness	☐Work injury	☐Lower back pain	☐Stomach/digestive trouble
☐Mid-back pain	☐Loss of energy	☐Lack of exercise	☐Frequent colds/flus

Are You Pregnant?

☐Yes ☐No ☐Not Sure Day 1 of your last menstrual period:

NOTE: Your health information will be kept confidential. Any information that we collect about you on this form will be kept confidential in our office. If a claim is submitted to Medicare/Insurance, your health information on this form may be shared with Medicare/Insurance. Your health information which Medicare/Insurance sees will be confidential.

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