DR. ANDREA'S

CHIROPRACTIC
&
SPINAL DECOMPRESSION

Welcome

one 1
ABOUT YOU

Today's Date: ________________ File #: ________________

Patient Name: ____
LAST FIRST MI

What you prefer to be called:______________ Male Female

Birth date: __________ Age: ____ SS#:________________

Mailing Address: ______________________________________

____
CITY STATE ZIP

Home Phone #:____

Work Phone #: ____

Other Phone(s) #: _____________________________________

E-Mail Address: _______________________________________

Referred By: ____

Employer:_____________________ How Long?_________

Employer's Address: ___________________________________

____
CITY STATE ZIP

Occupation:____

Status: Minor Single Married Divorced Separated Widowed

Spouse's Name: _______________________________________

Do you have children? Yes No How many? ________

two 2
INSURANCE INFO

Co. Name: ____

Address: ____
CITY STATE ZIP

Insureds SS#: ____

Group # (Plan, Local, or Policy #): ____________________

Insureds Name: _______________________________________

Relation:________________ Date of Birth:___________

Insureds Employer: ____________________________________

Please inform front desk of 2nd. Insurance source.

three 3
REASON FOR VISIT

The reason for this is a result of work sports auto trauma chronic

(Explain what happened):____

____

Please describe the pain & its location:_________________________________

____

When did condition begin?__________________

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

Is this condition interfering with your: Work Sleep Daily Routine

If so, please explain: ____

Have you been treated by a Chiropractor before? Yes No

If so, whom? _______________________________ Phone#: ___________________

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four 4

IN EVENT OF EMERGENCY

Who should we contact?___________________________________

Relation:____

Home Phone #:___________________ Work Phone #: ____________

Who is your Medical Doctor? _____________ Phone #: _________________

five 5

HEALTH HISTORY

Are you taking any of the following medications?

Nerve pills Pain killers (including aspirin) Muscle relaxers Stimulants

Blood Thinners Tranquilizers Insulin Other(s)____________________

Do you have or ever had any of the following diseases or conditions?

Y	N		Y	N		Y	N	
		Heart Attack/Stroke			Heart Surge/Pacemaker			Heart Murmur
		Congenital Heart Defect			Mitral Valve Prolapse			Artificial Valves
		Alcohol/Drug Abuse			Venereal Disease			Hepatitis
		HIV +/Aids			Shingles			Cancer
		Frequent Neck Pain			Emphysema / Glaucoma			Anemia
		High/Low Blood Pressure			Psychiatric Problems			Rheumatic Fever
		Severe/Frequent Headaches			Kidney Problems			Ulcers/Colitis
		Fainting/Seizures/Epilepsy			Sinus Problems			Asthma
		Diabetes/Tuberculosis			Difficulty Breathing			Chemotherapy
		Lower Back Problems			Artificial Bones/Joints			Arthritis

Please list any other serious medical condition(s) you have or ever had:

____

Please list anything that you may be allergic to:__________________________

____

List previous surgeries/treatments with dates: ___________________________

____

List any past serious accidents with dates:______________________________

____

Family Health History: ____

____

Do you: Take Supplements or Vitamins? Yes No / Exercise? Yes No

Are you on a special diet: Yes No / Since:_________________________

Do you smoke? No Yes / How Much? ______________ How Long? _________

Are you wearing: Heel Lifts Sole lifts Inner soles Arch supports

What is the age of your mattress? ________ Is it comfortable? Yes No

Are you Pregnant? No Yes / How long?__________ Nursing? Yes No

six 6

ACCOUNT INFO

Person ultimately responsible for account

Name:_______________________________

Relation:_____________________________

Billing Address: ______________________

____

CITY STATE ZIP

SSN: ________________________________

D.L.#: _______________________________

Work Phone#: _________________________

Payment method: Cash Check

____

Credit Card - Enter card # above (if accepted)

________ Initials I hereby authorize assignment of my insurance rights and benefits directly to the provider for services rendered. I fully understand I am solely responsible for any balance not paid by my insurance company (if offered at this office).

We invite you to discuss with us any questions regarding our services. The best health services are based on a friendly, mutual understanding between provider and patient.

Our policy requires payment in full for all services rendered at the time of visit, unless other arrangements have been made with the business manager. If account is not paid within 90 days of the date of service and no financial arrangements have been make, you will be responsible for legal fees, collection agency fees, and any other expenses incurred in collecting you account.

I authorize the staff to preform any necessary services needed during diagnosis and treatment. I also authorize the provider and or managed care organization, to release any information required to process insurance claims.

I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes to the information I have provide.

Signature____ Date: ____________________

Adult Patient Parent or Guardian Spouse

8222 E. 103rd St. Suite 123 • Tulsa, OK 74133 • 918-364-2225

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Health Information

GENERAL INFORMATION

First Name: ____________________

Middle Initial:_____ Last Name: ____________________

Race:
- ❑ American Indian
- ❑ Alaska Native
- ❑ Asian
- ❑ White
- ❑ African American
- ❑ Other Pacific Islander
- ❑ Declined to State

Ethnicity:
- ❑ Hispanic or Latino
- ❑ Not Hispanic or Latino
- ❑ Declined to State

Preferred Language: ____________________

Email Address: ____________________

OFFICE USE ONLY

Account Number: ____________________

Patient Height: ____________________

Patient Weight: ____________________

Patient BMI: ____________________

Patient Blood Pressure: ____________________

Smoking Status:
- ❑ Current Every Day Smoker Smoking Start Date: ____________ End Date: ____________
- ❑ Current Some Day Smoker
- ❑ Former Smoker
- ❑ Never Smoker
- ❑ In an effort to quit smoking, I am currently taking: ____________________

Do you have any allergies to medication? ❑ Yes ❑ No

If yes, please indicate the following:

Allergy: ____________________
Reaction: ____________________
Start Date: ____________________
End Date: ____________________

Allergy: ____________________
Reaction: ____________________
Start Date: ____________________
End Date: ____________________

Allergy: ____________________
Reaction: ____________________
Start Date: ____________________
End Date: ____________________

Allergy: ____________________
Reaction: ____________________
Start Date: ____________________
End Date: ____________________

Are you currently taking any new medication since your last visit? ❑ Yes ❑ No

If yes, please indicate the following:

Medication: ____________________
Route: Oral
Intravenous
Other: ____________________
Frequency: ____________________
Began Use: ____________________
Discontinued Use: ____________________

Medication: ____________________
Route: Oral
Intravenous
Other: ____________________
Frequency: ____________________
Began Use: ____________________
Discontinued Use: ____________________

Medication: ____________________
Route: Oral
Intravenous
Other: ____________________
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