

LOCKPORT CHIROPRACTIC
DR. TIMOTHY E. RADCLIFFE
1025 E. 9TH STREET
LOCKPORT, IL 60441

DATE: _____

FULL NAME: _____

NAME OF SPOUSE OR GUARDIAN: _____

SPOUSE SOCIAL SECURITY NUMBER _____ SPOUSE DATE OF BIRTH _____

ADDRESS: _____
CITY STATE ZIP

TELEPHONE: __ () _____ SOCIAL SECURITY NUMBER: _____

BIRTHDATE: _____ NO. OF CHILDREN: _____ PREGNANT? _____

OCCUPATION: _____

EMPLOYERS NAME/ ADDRESS/ PHONE: _____

SPOUSE'S OCCUPATION/ EMPLOYER: _____

NAME AND ADDRESS OF NEAREST RELATIVE: _____
(NOT LIVING WITH YOU)

WHO MAY WE THANK FOR REFERRING YOU TO US? _____

LIST CHIROPRACTORS YOU HAVE SEEN BEFORE:

1. NAME: _____ ADDRESS: _____
WHEN: _____ DIAGNOSIS: _____

2. NAME: _____ ADDRESS: _____
WHEN: _____ DIAGNOSIS: _____

LIST MEDICAL DOCTORS CONSULTED WITHIN THE PAST YEAR:

1. NAME: _____ ADDRESS: _____
WHEN: _____ DIAGNOSIS: _____

2. NAME: _____ ADDRESS: _____
WHEN: _____ DIAGNOSIS: _____

3. PRESENT FAMILY DOCTOR: _____ ADDRESS: _____

4. DATE OF LAST PHYSICAL EXAMINATION: _____

LIST PROBLEMS OR COMPLAINTS ACCORDING TO SEVERITY OF PAIN	DATE STARTED, OR FOR HOW LONG	IF YOU'VE HAD THE CONDITION BEFORE, WHEN?	DID PROBLEM BEGIN WITH AN INJURY?
1. _____	_____	_____	_____
2. _____	_____	_____	_____
3. _____	_____	_____	_____
4. _____	_____	_____	_____

NAME OF PERSON RESPONSIBLE FOR PAYMENT: _____

DO YOU HAVE INSURANCE THAT COVERS CHIROPRACTIC? _____

NAME OF INSURANCE COMPANY: _____ POLICY NO. _____

SURGERY: (PLEASE INCLUDE ALL SURGERIES)

1. TYPE: _____ WHEN?: _____ DOCTOR: _____
2. TYPE: _____ WHEN?: _____ DOCTOR: _____
3. TYPE: _____ WHEN?: _____ DOCTOR: _____
4. TYPE: _____ WHEN?: _____ DOCTOR: _____

ACCIDENTS AND/OR INJURIES: (ESPECIALLY THOSE RELATED TO YOUR PRESENT PROBLEMS)

1. TYPE: _____ WHEN?: _____ HOSPITALIZED?: _____
2. TYPE: _____ WHEN?: _____ HOSPITALIZED?: _____
3. TYPE: _____ WHEN?: _____ HOSPITALIZED?: _____
4. TYPE: _____ WHEN?: _____ HOSPITALIZED?: _____

******* NOTE: IF YOU HAVE RECENTLY BEEN INVOLVED IN AN ACCIDENT OR INJURY, PLEASE REQUEST AND FILL OUT OUR REPORT FORM WHICH MAY BE OBTAINED FROM THE FRONT DESK!*******

CHECK THE FOLLOWING CONDITIONS YOU MAY HAVE HAD OR DO HAVE NOW:

_____ ALCOHOLISM	_____ DEPRESSION	_____ HIV	_____ PLEURISY
_____ ALLERGY	_____ DIABETES	_____ IRREGULAR PERIODS	_____ PNEUMONIA
_____ AHEMIA	_____ DIARRHEA	_____ LOW BLOOD SUGAR	_____ POLIO
_____ ARTERIOSCLEROSIS	_____ ECZEMA	_____ MALARIA	_____ RHEUMATIC FEVER
_____ ARTHRITIS	_____ EMPHYSEMA	_____ MEASLES	_____ RINGING IN EARS
_____ ASTHMA	_____ EPILEPSY	_____ MENSTRAL CRAMPS	_____ SINUS
_____ BACKACHES	_____ GALL BLADDER	_____ MIGRAINE	_____ STROKE
_____ BACK PAIN	_____ GOUT	_____ MISCARRIAGE	_____ THYROID PROBLEMS
_____ CANCER	_____ HEADACHES	_____ MULTIPLE SCLEROSIS	_____ TUBERCULOSIS
_____ COLD SORES	_____ HEART ATTACK	_____ MUMPS	_____ ULCERS
_____ CONSTIPATION	_____ HEART DISEASE	_____ NECK PAIN	_____ VENEREAL DISEASE
_____ CONVULSIONS	_____ HIGH BLOOD PRESSURE	_____ NERVOUSNESS	_____ WHOOPING COUGH

I UNDERSTAND AND AGREE THAT HEALTH AND ACCIDENT INSURANCE POLICIES ARE AN ARRANGEMENT BETWEEN AN INSURANCE CARRIER AND MYSELF. FURTHERMORE, I UNDERSTAND THAT LOCKPORT CHIROPRACTIC MAY 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 LOCKPORT CHIROPRACTIC WILL BE CREDITED TO MY ACCOUNT ON RECEIPT. HOWEVER, I CLEARLY UNDERSTAND AND AGREE THAT ALL SERVICES RENDERED ME ARE CHARGED DIRECTLY TO ME, AND THAT I AM PERSONALLY RESPONSIBLE FOR PAYMENT. I ALSO UNDERSTAND THAT IF I SUSPEND OR TERMINATE MY CARE AND TREATMENT, ANY FEES FOR PROFESSIONAL SERVICES RENDERED ME WILL BE IMMEDIATELY DUE AND PAYABLE.

PATIENT'S SIGNATURE: _____ DATE: _____

GUARDIAN OR SPOUSE'S SIGNATURE: _____ DATE: _____

INFORMATION TAKEN BY: _____ DATE: _____