COAST CHIROPRACTIC CENTERS

INFORMATION/APPLICATION FOR CARE

Patient's name_____ What name do you prefer to go by?_____

Home address_____ City _____ State_____ Zip code_____

Home phone (____) _____-_____ **Cell phone (____) _____-_____** Patient's S.S # _____

Date of birth _____/_____/_____ Age_____ Male ☐ Female ☐ Status: S M W D

Email _____@_____ (We send our periodic health tips and special information as it becomes available through E-mail)

Maiden name_____ children ages/sex:

Is any member of your family a patient at this office? YES ☐ NO ☐ Relationship_____

How were you referred to our office? Name of the person that referred you: _____

☐ Phone book ☐ Outside lecture ☐ Billboard Ad ☐ Spinal Health Care Class ☐ Another Physician
☐ Friend ☐ Val-Pak Coupon ☐ Info. In mail ☐ Newsletter ☐ Newspaper Ad ☐ Office Sign ☐ Dr. Tim Harcourt
☐ Family member ☐ Mall/Health Fair ☐ Radio Ad ☐ Insurance Company ☐ Attorney ☐ Other

Your Employer _____ Your Position_____

Employer's address _____ City _____ State_____ Zip code_____

Employer's Phone Number (_____)_____-_____ Ext._____

Spouse's Name _____ Spouse's Employer _____

Spouse's Position_____ Spouse's Employer's Number (_____)_____-_____ Ext. _____

Emergency Contact _____ Home phone (____) _____-_____ Cell phone (____) _____-_____

_____/_____/_____ Date injury or illness began? Are you ☐ right or ☐ left handed?

☐ Yes ☐ No Have you ever had the same or similar symptoms? Explain _____
☐ Yes ☐ No Is this condition the result of pregnancy? **If yes, estimated due date: ____/____/_____**
☐ Yes ☐ No Is your present health problem the result of a work related accident?
☐ Yes ☐ No If yes, was your employer notified?
☐ Yes ☐ No Is your present health problem the result of a motor vehicle accident?
☐ Yes ☐ No Is there an open insurance claim in process now?
☐ Yes ☐ No May we call you at work for additional information if necessary?
☐ Yes ☐ No Have you lost any time from work?
☐ Haven't returned to work at this time
☐ Returned to work on ____/____/_____ Dates of disability ____/____/_____ to ____/____/_____

Hospital Preference ☐ Hospital ☐ Other_____
Name of Family Doctor_____ Phone # (_____)_____-_____ Date of last exam: _____/_____/_____
Best time to reach? _____ a.m. _____ p.m.

PAYMENT GUARANTEE / AUTHORIZATION TO RELEASE INFORMATION

In consideration of Coast Chiropractic Centers, Ft Myers, FL rendering care and/or treatment to the patient named below, I/we the undersigned promise to pay Coast Chiropractic Centers, in full, upon demand, all expenses and charges for such care or treatment. I/we that, if as a courtesy, Coast Chiropractic Centers bills my/our insurance company, this is no way relieves my/our obligation.

I authorize Coast Chiropractic Centers to release to any third party reimburser, your employer, hospital or continued care facility such information for this condition as may be necessary for the evaluation and/or payments of my medical claim or continuation of care after release. I also authorize all healthcare providers, hospitals, offices and clinics where I have been a patient to release to Coast Chiropractic Centers information relative to my medical history or condition.

In the event it is necessary to engage the services of a collection agency or attorney for collection of this claim, I/we agree to be responsible for reasonable fees and costs charges by said agency or attorney for collection.

I have had this form fully explained to me and I/we have read it and I/we fully understand and accept its terms and conditions. A photocopy of this agreement shall be considered as effective and valid as the original.

Signature_____Witness_____ Date_____/_____/_____
(Patient or Authorized Representative)

PREGNANCY RELEASE

This is to certify that, to the best of my knowledge, I am NOT pregnant and that the COAST CHIROPRACTIC CENTERS has permission to take X-rays.

Signature_____ Date _____/_____/_____