APPLICATION FOR CARE

Please complete all questions to better serve you. PLEASE PRINT. If you need help please ask the receptionist.

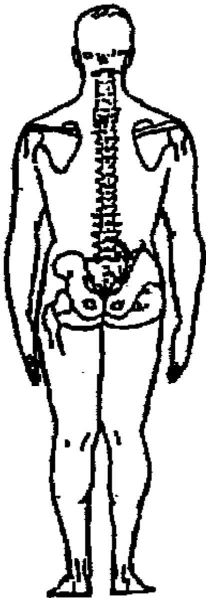
Date _____________

Name ____ E-Mail ________________________
Contact #s: Cell __________________ Home __________________ Work _________________
Address ___________________________________ City __________________ State _____ Zip ________
Age _____ Birth date __________________ Marital Status: S M W D Number of Children ______

Please circle one payment type: Cash Check Master Card/Visa

Your Employer _______________________________ Occupation ____________________ Years On Job ____
Employer Address ______________________________ City __________________ State _____ Zip ______
Your Social Sec # ___________________
Do you have Medicare? Yes ____ No ____ Medicaid? Yes ____ No ____
Emergency contact: Name ____________________________ Relationship ____________ Phone _______________

Name of Spouse or Parent ____________________________________ Phone # ___________ Their Birthdate __________
Spouse: Employed By _____________________________ Occupation ____________________



COMPLETE THESE DIAGRAMS

Please mark the exact location of your symptoms on the diagram.

Then list and describe the type and frequency of your condition, as well as any activity which brings it on or aggravates it – such as, "dull, sharp, constant, off & on, when standing, when sitting" etc.

MAJOR COMPLAINTS

1.____
____
2.____
____
3.____
____
4.____

Is your condition due to an accident? Yes ____ No ____ Date ________

- If Yes, what type? Auto ___ Work___ At Home ___ Other ___

Have you **ever** been in an auto accident? Yes ____ No ____ When ______
Have you **ever** been knocked unconscious? Yes ____ No ____ When ______

Rate how your **Primary** complaint affects your daily life on a scale from 1 (mild) to 10 (severe pain) ______

Referred to our office by: ____________________________________

- Pregnancy: Woman Only: Are you Pregnant? Yes ____ No ____ Date your last period began: _________

If there is a chance that you may be pregnant, let the doctor or assistant know right now.

I (we) agree to pay for services rendered to the above mentioned patient as the charge is incurred. I understand and agree that health & accident insurance policies are an arrangement between an insurance carrier and myself and that I am personally responsible for payment of any and all services covered or not covered. I also understand that if I suspend or terminate my care and treatment, any fee for professional services rendered me will be immediately due and payable.

Patient's Signature ____ Date ________________________

Or Guardian Signature ____ Date ________________________

Notice to our new patients: Full payment for services rendered is due at the end of each visit. If for any reason this request cannot be met, arrangements should be made in advance before seeing the doctor.

Beth EL Wellness & Chiropractic 170 Claremont Drive Elkin, NC 28621 336-258-8889