dr. Haggs

Sports Chiropractic and Health Center

Application For Treatment

Date:_____ (Please Print Clearly)
Name:_____ Age:_____ Birthday Date: _____
If minor, name of Mother: _____ Father:_____
Address:_____ City:_____ State:_____ Zip:_____
Home Phone: _____ Work:_____ Cell: _____
E-Mail:_____
Occupation:_____ Employer:_____
How were you referred to our office?:_____

General Health History

Have you been treated for any health condition by a physician in the last year? ☐ Yes ☐ No
If yes, explain: _____
Have you previously received Chiropractic treatment? ☐ Yes ☐ No
If yes, list dates consulted and for what problems:_____
_____
Are you pregnant? ☐ Yes ☐ No
Please List the drugs you are currently taking: _____
List the approximate dates of any operations, unusual diseases, serious accidents you have had (include any broken bones):_____
_____
Have you ever been in an automobile accident? ☐ Past Year ☐ Past 5 Years ☐ Over 5 Years

Financial Responsibility

Who is responsible for your bill? ☐ Self ☐ Insurance
Type of Insurance: ☐ Health Insurance ☐ Auto Insurance
Insurance Company Name and Address: _____
_____
If insurance is in any name other than yourself, please provide name and date of birth of insured:
_____
Is there any secondary policy that you have health insurance through? ☐ Yes ☐ No
If yes, please provide insurance company's name and address and insured's name, address and date of birth:
_____
_____

Fees are payable at the time Examinations, X-Rays, and Treatments are received, unless other arrangements have been made in advance. X-rays remain the property of this office. I hereby give permission for treatment.

Patient Signature:_____
Social Security Number:_____-_____-_____
Date:_____