

INFORMATION/APPLICATION FOR CARE

The following information is needed in order to better serve you. Please complete all questions. If you need help please ask the receptionist. PLEASE PRINT.

Name _____ Home Phone _____ Work Phone _____ Today's Date _____
 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 American Express Discover
 Your Employer _____ Occupation _____ Years on Job _____
 Employer Address _____ City _____ State _____ Zip _____

Insurance Company _____ Your Social Security # _____
 Do you have Medicare? Yes ___ No ___ Do you have Medicaid? Yes ___ No ___

Name of Spouse or Parent _____ Their Birth Date _____

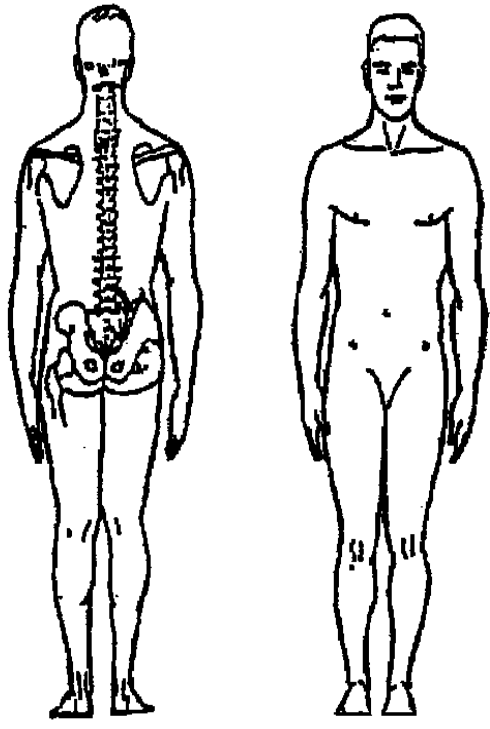
Spouse Employed By _____ Occupation _____ Years on Job _____

Employer Address _____ City _____ State _____ Zip _____

Office Phone # _____ Spouse's SS# _____ Driver's License # _____

Does your spouse have health insurance at work? Yes ___ No ___

COMPLETE THESE DIAGRAMS



If you are in pain, please mark the exact location of your pain on the diagram. Also describe the type and frequency of your pain, as well as any activity which brings on or aggravates the pain. For example; dull, sharp, consistent, off & on, when standing, when sitting, etc.....

MAJOR COMPLAINTS

(Please list any condition you are being treated for or are experiencing.)

Referred to our office by: _____

How payment will be made:

Type of Insurance:

_____ Cash _____ Worker's Comp. _____ Health Insurance
 _____ Check _____ Credit Card _____ Automobile Insurance Policy



Ault Chiropractic of Hudson
130 W. Streetsboro St., Suite 2
Hudson, OH 44236
T: 330.342.0755
F: 330.342.0752

Is your condition due to an accident? Yes _____ No _____ Date of accident? _____

Type of Accident? Auto _____ Work/On Job _____ At Home _____ Other _____

Have you ever been in an auto accident? Past Year _____ Past 5 Years _____ Over 5 Years _____ Never _____

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.

Insurance cases: On all insurance assignments, the deductible should be met in the beginning unless prior arrangements are made.

IN CASE OF EMERGENCY: (Name of relative or close friend not living in your home):

NAME: _____ PHONE: _____

ADDRESS: _____

**PLEASE CONTINUE AND COMPLETE THE
CONFIDENTIAL CASE HISTORY
THANK YOU.**