



**Confidential Patient Information**

Date \_\_\_\_\_

ID# \_\_\_\_\_

Name \_\_\_\_\_ Sex M \_\_\_ F \_\_\_ Date of Birth \_\_\_ / \_\_\_ / \_\_\_ Age \_\_\_\_\_  
Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Home Ph \_\_\_\_\_ Work Ph \_\_\_\_\_ Cellular \_\_\_\_\_  
Circle One: Single Married Widowed Divorced Separated Number of Children: \_\_\_\_\_  
Email \_\_\_\_\_ SS# \_\_\_\_\_ Drivers Lic.# \_\_\_\_\_  
Employer \_\_\_\_\_ Occupation \_\_\_\_\_ How Long? \_\_\_\_\_  
Spouse Name \_\_\_\_\_ DOB \_\_\_ / \_\_\_ / \_\_\_ Spouse SS# \_\_\_\_\_  
Spouse Employer \_\_\_\_\_ Spouse Work Ph \_\_\_\_\_ Cell# \_\_\_\_\_

Referred to this office by: \_\_\_\_\_

**Insurance Information**

Self Pay \_\_\_ Medicare \_\_\_ Medicaid \_\_\_ Other Health Ins \_\_\_\_\_

Insurance: \_\_\_\_\_ Phone: \_\_\_\_\_  
Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Name of Insured: \_\_\_\_\_ Policy, Claim or ID# \_\_\_\_\_  
Group Name & Number \_\_\_\_\_ Group Name: \_\_\_\_\_

**Emergency Contact (permanent address of family member or friend)**

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Ph \_\_\_\_\_  
Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

**Current Condition of Health**

The reason for seeking services: \_\_\_\_\_  
When did this condition begin: \_\_\_\_\_ Has this condition occurred before? \_\_\_\_\_ When: \_\_\_\_\_  
Other Dr's. seen for this condition: \_\_\_\_\_ type of treatment \_\_\_\_\_  
Results: \_\_\_\_\_  
Condition is: Job Related \_\_\_ Auto Accident \_\_\_ Home Injury \_\_\_ Fall \_\_\_ Other \_\_\_\_\_  
Have you made a report of this accident or injury to anyone? \_\_\_\_\_ Who? \_\_\_\_\_  
List any medications you are on and what they are treating: \_\_\_\_\_

**Terms and Conditions of Treatment:**

I authorize any party, including, but not limited to Dr. Terry and/or associates, my insurance carrier and my employer to release any information necessary to assist in filing, processing for paying any insurance claims. I understand that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that the Doctor's Office will 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 the Doctor's Office 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, and fees for professional services rendered me will be immediately due and payable. A copy of the privacy policies of the practice have been made available to me.

I hereby authorize Dr. Terry and associates to treat my condition as deemed appropriate through the use of diagnostic testing and manipulation throughout my spine. It is understood and agreed that the amount paid for X-rays is for examination only and the X-ray negatives will remain the property of this office, being on file where they may be seen at any time while a patient of this office. The patient also agrees that he/she is responsible for all bills incurred at this office. The Doctor will not be held responsible for any pre-existing medically diagnosed conditions, nor for any medical diagnosis.

You have the right to have a third party present during any examination or treatment by Dr. Terry or associates. You may waive this right if you so desire. Your signature below indicates that you understand and accept all above mentioned terms and have waived the right to have a third party present during all examinations. If for any reason you wish to have a third party present for a specific examination, please let Dr. Terry or a staff member know and we accommodate your wishes.

Patient Signature X \_\_\_\_\_ Date \_\_\_\_\_



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Spouse Name \_\_\_\_\_ DOB \_\_\_ / \_\_\_ / \_\_\_ Spouse SS# \_\_\_\_\_  
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