NEW PATIENT APPLICATION

Welcome to our Practice! Please thoroughly complete all questions. Thank you.

Name: _____ Today's Date: _____

Address: _____

City/State/Zip: _____ E-Mail: _____

Phone: Home _____ Work: _____ Fax: _____

Cell #:_____ Pager: _____ Marital status: M/W/D/S

Birth date: ____/____/____ Age: _____ Social Security #: _____

Who may we thank for referring you? _____

Your prior doctor of chiropractic and address: _____

Chiropractic techniques you've had success with: _____

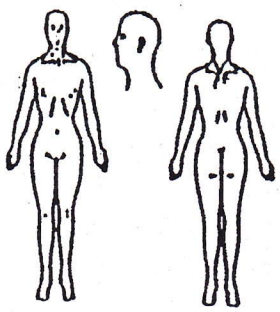
Last time you went to previous doctor of chiropractic _____

General practitioner: _____ City _____

Your employer: _____ Phone number: _____

Employer's address: _____

Occupation: _____ Mark area(s) of Health Concerns
Spouse's name: _____



Spouse's employer: _____

Children's names & ages: _____

Favorite hobbies or interests: _____

_____

Method of payment for first visit:
_____Cash _____Check _____MAC _____Credit Card

Health reasons for consulting our office:
1. _____ 3. _____

2. _____ 4. _____

Have you had same or similar problem(s) before? ___ Yes ___ No

How long? _____ Please explain:

_____

Father/Mother/Brother/Sister/Children with similar problems?

_____

Is this the result of an auto or work injury? _____ If so, when? _____

If this is a work injury, is there a panel chiropractor that your company's Workman's Compensation Insurance requires you to see in the first 90 days? If so, please list their name.

_____

Other doctors who have treated this problem: _____

_____

Surgery you have had: _____

Medication(s) you currently take: _____

Is there any chance you are pregnant? Yes___ No___

What have you heard about chiropractic care?

_____

Do you know what a subluxation is? If yes, please describe

_____

What daily rituals for spinal health do you presently practice?

_____

Have you ever been diagnosed with cancer? _____

If so, what type? _____

Do you have health insurance? _____ Name of company: _____

The above information is true and accurate to the best of my knowledge. My reason for consultation with the doctor is for evaluation of my physical health and the potential for improvement.

Patient or Guardian Signature: _____ ***Date:***
_____/_____/_____

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that this office will submit my claim, or gives me a receipt to submit to my insurance carrier for reimbursement. I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. It is my understanding that my credit may be checked if Lincoln Disc and Nutrition Center extends credit to me and I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered to me will be immediately due and payable, unless prior arrangements are made. I authorize the release of any information acquired in the course of my examination or treatment. I certify that the above information is true and correct.

Patient's (Parent or Guardian's) Signature: