AULT CHIROPRACTIC
HUDSON • BRIMFIELD

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

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.

PATIENT INFORMATION:

Date _____ Name _____

Cell Phone _____ **(APT. Text Alerts _____)** Home Phone _____Work Phone _____

Address _____ City _____ State _____ Zip _____

Birth Date _____ Age _____ Marital Status: S M W D Number of Children _____

Employer _____ Occupation _____

Employer Address _____ City _____ State _____ Zip _____

SS# _____ Driver's License ST___#_____ Email _____ **(ALERTS_____)**

SPOUSE OR PARENT INFORMATION:

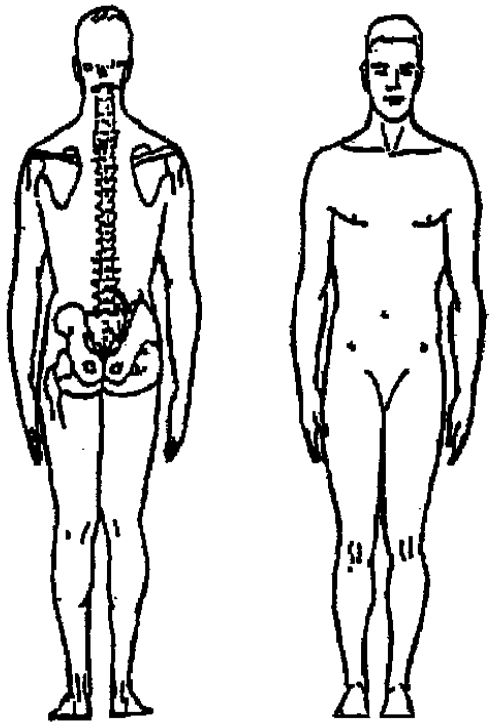
Name _____ Spouse Employed By _____

Occupation _____ Birth Date _____

Employer Address _____ City _____ State _____ Zip _____

IN CASE OF EMERGENCY: NAME: _____PHONE: _____

ADDRESS: _____



Referred to our office by: _____

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.)

_____
_____
_____
_____
_____
_____
_____

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 _____

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INSURANCE INFORMATION :

Primary Insurance Company Name _____ Secondary _____
Do you have Medicare? Yes ____ No ____ Do you have Medicaid? Yes ____ No ____
How payment will be made: _____ Cash/Check _____ Worker's Comp.
_____ Credit Card _____ Automobile Insurance Policy

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.

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: _____
Guardian Signature: _____ Date: _____

PLEASE CONTINUE AND COMPLETE THE
CONFIDENTIAL CASE HISTORY
THANK YOU.

MINOR:

I _____ (legal guardian) KNOWINGLY AUTHORIZE AULT CHIROPRACTIC, TO PROCEED WITH CHIROPRACTIC CARE AND TREATMENT WITH THE UNDERSIGNED MINOR.

WHEN THE PATIENT IS A MINOR, OR UNABLE TO CONSENT:

1. THE PATIENT IS A MINOR _____ YEARS OF AGE.
2. OTHER _____

PATIENT NAME: _____

PERSON AUTHORIZED TO SIGN FOR THE PATIENT:

NAME (PRINT):_____

SIGNATURE OF AUTHORIZED PERSON: _____

PHYSICIAN SIGNATURE: _____