SIEGEL CHIROPRACTIC, L.L.C.
Bennett E. Siegel, B.S., D.C.
28 East Main Street
Avon, CT 06001
(860) 674-1992

FILE:

HEALTH HISTORY FORM

(Please print clearly)

Is your visit today due to an auto accident or job related injury? [ ] yes [ ] no

Name____________________Street Address______

Home Phone (__)___________City_____________________ St_____Zip

Date of Birth___/___/___ Mailing Address

Social Security No.____/____/____ City____________________St_____Zip

Sex: M F Martial Status: S M D W Anniversary Date

Number of Children

Your Employer

Work Phone (___)____________ Address

Occupation__________________ City______________________St_____Zip

The following section refers to your spouse, or if a minor, the responsible party:

Name__________________Date of Birth___/___/___Social Security No.____/____/

Employer___________________________________Work Phone(___)

Address___________________________ City_______________ St_____ Zip

Whom may we thank for referring you to our office?___________________

Who is financially responsible for this bill? ________________________

I will be paying today by: [ ] cash [ ] check [ ] charge card

Name of previous chiropractor_____________________________Phone(___)

Address______________________City_____________________St______Zip

What were the results?

Date of last: Chiropractic Adjustment_________________ Spinal Examination

Spinal X-ray

Name of medical doctor___________________________Phone (___)

Address________________________City_____________St_______Zip

Date of last: Physical____________Blood Test(s)____________ Urinalysis

Chest X-ray_________________Dental X-ray

Type and date of other x-rays

Family History:	Cancer	Heart	Diabetes	Kidney	Back	Other Major Health Problems
Mother	[ ]	[ ]	[ ]	[ ]	[ ]	
Father	[ ]	[ ]	[ ]	[ ]	[ ]	
Brother (no. of __)	[ ]	[ ]	[ ]	[ ]	[ ]	
Sister (no. of __)	[ ]	[ ]	[ ]	[ ]	[ ]	

If you have had any of the following, indicate what years:

_______Alcoholism _______Goiter _____Pleurisy
_______Anemia _______Heart Disease _____Pneumonia
_______Appendicitis _______Hepatitis _____Polio
_______Arthritis _______High Blood Pressure _____Rheumatic Fever
_______Cancer _______Lumbago _____Tuberculosis
_______Chicken Pox _______Measles _____Ulcer
_______Diabetes _______Mental Disorder _____Venereal Disease
_______Eczema _______Mononucleosis _____Whooping Cough
_______Epilepsy _______Multiple Sclerosis
_______Gall Stones _______Mumps

If you have ever had the following, please note YEAR and DESCRIBE:

Had a fractured or broken bone

Been knocked unconscious

Used a cane/crutch/support/collar

Been treated for a spine or nervous condition

Worn heel/sole lifts/ shoe inserts, etc

Fall or accident

Trip to emergency room

Surgeries_________________________Tonsils______________ Appendix

Hospitalizations

Current drugs/medications (include dosage and how many years)

Take vitamins or minerals

Have or suspect allergies

What is your current MAJOR complaint

Is it related to an: Auto Accident Job Injury Home Injury Non-traumatic ?

When did this condition start?

Similar condition in the past? Yes No If yes, when and cause

Type of pain __________________ Duration_______________ Frequency

Is it getting progressively: Better Worse Same Constant Comes and Goes

Does it interfere with: Work Sleep Daily Routine Other

_Previous doctors and/or hospitals seen for THIS condition, the year, diagnosis and treatments:

What do you believe is wrong with you?

What is/are your current OTHER complaints?

For Female Patients only: Are you or might you be pregnant?

NOTE: Use the back of form if needed for further remarks and/or additional information.

Habits	None	Light	Medium	Heavy	Amount		None	Light	Medium	Heavy	Amount
Alcohol	[ ]	[ ]	[ ]	[ ]	___/week	Exercise	[ ]	[ ]	[ ]	[ ]	
Coffee	[ ]	[ ]	[ ]	[ ]	___c/day	Sleep	[ ]	[ ]	[ ]	[ ]	
Tea	[ ]	[ ]	[ ]	[ ]	___c/day	Appetite	[ ]	[ ]	[ ]	[ ]	
Tobacco	[ ]	[ ]	[ ]	[ ]	___/day						
Drugs	[ ]	[ ]	[ ]	[ ]							

OFFICE POLICY

Siegel Chiropractic, LLC. is committed to providing you with the best possible care. In order to achieve this goal, we need your assistance and understanding of our payment policy. Payment for services is due at the time services are rendered. We accept cash, checks, money order, Master Card, Visa, American Express or Discover Card. We are not participating with any insurances. Connecticut Health Plan is the only network we are in. You may, however, have out-of-network coverage. If so, we are anxious to help you receive your maximum allowable benefits. We will be happy to provide you with an insurance-acceptable itemized bill for each visit for you to submit to your health insurance carrier. Your insurance policy is between your and your insurance company. Siegel Chiropractic, LLC is not responsible for entering into any dispute with your insurance company. If there are any changes in your personal information (ie: address, phone number, or employer) or if you have been involved in a recent accident or injury, it is your responsibility to notify the front desk immediately, prior to seeing the doctor. New forms need to be filled out and signed. All supplements, regardless of insurance status, are rendered on a "COD" basis. Due to our scheduling requirements, any patient who cancels or does not come in as scheduled for their appointment without giving our office a 24 hour notice may be charged a missed appointment fee.

I understand and agree that, regardless of my insurance status, I am responsible for the balance on my account for any professional services rendered. In the event my insurance company requests information from Dr. Siegel, regardless of whether or not the office submits and accepts assignment of my claims, I authorize the release of any information requested for the purpose of processing such claims. I also understand that Siegel Chiropractic, LLC reserves the right to send any unpaid accounts to collections if necessary.

Signature of Patient or Guardian **Date** **Signature of Spouse or Witness** **Date**

CONSENT FOR TREATMENT TO PROCEED

I understand that if I am accepted as a patient by the Physicians of Siegel Chiropractic, L.L.C. I authorize them to proceed with any treatment they deem necessary. Furthermore, any risks regarding chiropractic treatment will be explained to me upon request.

Patient's Signature **Date**