

Siegel Chiropractic, L.L.C.

Bennett E. Siegel, B.S., D.C.

16 Brick Walk Lane, Unit 2

Farmington, CT 06032

(860) 674-1992

FILE:

DATE:

Health History Form

(Please print clearly)

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

Is **MEDICARE** your primary insurance? [] yes [] no

Name _____ Home () _____ Cell () _____

Street Address _____ City _____ State _____ Zip _____

Mailing Address _____ City _____ State _____ Zip _____

Date of Birth ____/____/____

Sex: M F Marital Status: S M D W

Number of Children _____

Your Employer _____

Occupation _____ Work Phone () _____

Address _____ City _____ State _____ Zip _____

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

Name _____ Date of Birth ____/____/____

Work Phone() _____

Employer _____

Address _____ City _____ State _____ 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 _____ State _____ Zip _____

What were the results? _____

Date of last: Chiropractic Adjustment _____ Spinal Examination _____

Spinal X-ray _____

Name of Medical Doctor _____ Phone() _____

Address _____ City _____ State _____ Zip _____

Date of last: Physical _____ Blood Test(s) _____ Urinalysis _____

Chest X-ray _____ Dental X-ray _____

Type and date of other X-rays or scans _____

Family History:	Cancer	Heart	Diabetes	Kidney	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 (list) _____

Have or suspect allergies (list) _____

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, and money orders, Master Card, Visa, American Express or Discover Card. We are not participating with any insurance. 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 you 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.

_____ **Date**_____ _____ **Date**_____

Signature of Patient or Guardian

Signature of Spouse or Witness

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**_____