Siegel Chiropractic, L.L.C.
Bennett E. Siegel, B.S., D.C.
28 East Main Street
Avon, CT 06001
(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_____/_____/_____
Social Security No._____ 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_____