High Desert Chiropractic & Massage

Brandi Kuhn, DC,CCSP Joshua Kuhn, DC Jeremy Holbrook, DC

## Patient Information

Date_____
Patient_____
Address_____
_____
Sex: M F Age_____ Birthdate_____
Referral:_____
Email:_____

☐ Single ☐ Married ☐ Widowed
☐ Divorced ☐ Partnership

Patient SS#_____
Occupation_____
Employer_____
Employee Address_____
Employer Phone_____
Spouse's Name_____

## Account

Who is responsible for this account?_____

Will this account be paid by Cash or Insurance

**Assignment and Release**

I, the undersigned certify that I (or my dependent) have insurance coverage with _____ and assign directly to Dr. _____ all insurance benefits. If any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I herby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

_____
Responsible Party Signature

_____ _____
Relationship Date

## Phone Numbers

Home_____Work_____Cell_____
Best time and place to reach you?_____

IN CASE OF EMERGENCY, CONTACT:

Name_____Relationship_____
Home Phone_____
Work Phone_____Ext._____
Cell Phone_____

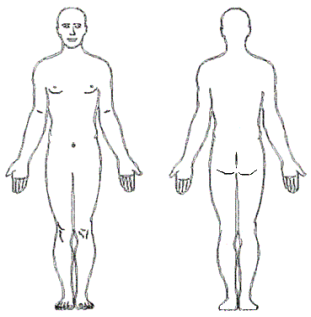
## Accident Information

Is condition due to an accident?_____
Date_____
Type of accident ☐ Auto ☐ Work ☐ Home ☐ Other

To whom have you made a report of your Accident?
☐ Auto Insurance ☐ Worker Comp
☐ Employer ☐ Other
Attorney Name and Address (if applicable)
_____
_____

## Patient Condition

Reason for visit_____
When did your symptoms appear_____
Is this condition getting progressively worse? Yes, No, Unsure
Mark an X on the picture where you continue to have pain, numbness or tingling.
Rate the severity of your pain on a scale from 1 (least pain) to 10 (severe pain)_____
Type of pain: sharp, dull, throbbing, numbness, aching, shooting , burning, tingling, cramps, stiffness, swelling, other _____
How often do you have this pain?_____
Is it constant or does it come and go?_____
Does it interfere with your: work, sleep, daily routine, recreation
Activities or movements are painful to perform: sitting, standing, walking, bending, lying down, other _____
_____



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