four 4 In Event of Emergency

Who should we contact?_____

Relation:_____

Home Phone #:_____ Work Phone #:_____

five 5 Health History

Are you taking any of the following medications? ❑ No

❑ Nerve Pills ❑ Pain Killers (including asprin) ❑ Muscle relaxers ❑ 'Pep' pills ❑ Blood Thinners ❑ Tranquilizers ❑ Insulin

❑ Other(s):_____

Have you had any of the following diseases/medical conditions?

❑ Heart Attack / Stroke	❑ Heart Surge / Pacemaker	❑ Heart Murmur	❑ Diabetes / Tuberculosis
❑ Congenital Heart Defect	❑ Mitral Valve Prolapse	❑ Artificial Valves	❑ Low Back Problems
❑ Alcohol / Drug Abuse	❑ Venereal Disease	❑ Hepatitis	❑ Digestive Problems
❑ HIV / AIDS	❑ Shingles	❑ Cancer	❑ Difficult Breathing
❑ Frequent Neck Pain	❑ Emphysema / Glaucoma	❑ Auemia	❑ Artificial Bones / Joints
❑ High / Low Blood Pressure	❑ Psychiatric Problems	❑ Rheumatic Fever	❑ Reproductive Problems
❑ Severe / Frequent Headaches	❑ Kidney Problems	❑ Ulcers / Colitis	❑ Chemotherapy
❑ Fainting / Seizures / Epilepsy	❑ Sinus Problems Epilepsy	❑ Asthma	❑ Arthritis
			❑ Menstrual Problems

Please list any other serious medical conditions you have or have had:_____

Please list anything that you might be allergic to:_____

List previous surgeries / treatements with dates:_____

Do you smoke? ❑Yes ❑ No; Drink alcohol? ❑Yes ❑ No; Drink Coffee? ❑Yes ❑No

Are you wearing: ❑ Heel lifts ❑ Sole lifts ❑ Inner soles ❑ Arch supports?

What is the age of your mattress?_____ Is it comfortable? ❑ Yes ❑ No

What is your height?_____ Weight? _____

FOR WOMEN: Are you taking Birth Control? ❑ Yes ❑ No; Are you pregnant? ❑ Yes / How long?_____ ❑ No; ❑ Nursing?

six 6 Account Info

Person ultimately responsible for account:

Name:_____

Relation:_____

Billing Address:_____

_____

City State Zip

SS #:_____

DL #:_____

Employer:_____

Work Phone #:_____

Desired Method of payment:

❑ Cash ❑ Check ❑ Credit Card (MasterCard / Visa)

CC #_____

Exp Date:_____

• We invite you to discuss with us any questions regarding our services. The best health services are based upon a friendly, mutual understanding between provider and patient.

• Our policy requires payment in full for all services rendered at the time of visit, unless other arrangements have been made with the office manager. I also understand that regardless of insurance coverage that I am ultimately responsible for my bill.

• I authorize the staff to perform any necessary services needed during evaluation and care. I also authorize the provider to release any information required to process insurance claims.

• I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes in my medical status.

Signature:_____

Date:_____