Karl Peterson D.C., N.D

CONSULTATION ADMITTANCE

(please print)

CONFIDENTIAL PATIENT INFORMATION DATE__________________________

NAME (*minor*)____

Mother & father's name: ____

ADDRESS____________________________________CITY/ST/ZIP__________________________

PHONE parent:(*home*)_________________(*work*)____________________(*cell*)_________________

AGE ____ BIRTHDATE ___/____/_____ S.S.# _____-_____-______

FATHER'S EMPLOYER________________________________ OCCUPATION_________________

EMPLOYER ADDRESS______________________________ CITY/ST/ZIP____________________

MOTHER'S EMPLOYER_______________________________ OCCUPATION_________________

EMPLOYER ADDRESS______________________________ CITY/ST/ZIP_____________________

REFERRED TO OUR OFFICE BY____

CHIEF COMPLAINT____

WHEN DID IT START________________________ *is it worse______ same________ better________*

OTHER DOCTOR(s) SEEN FOR THIS CONDITION____

DATE OF LAST PHYSICAL EXAM_______________WHERE________________________________

FAMILY HISTORY: *KEY: M-mother F-father B-brother S-sister SELF-self*

Rheumatic Fever______ Emphysema________ Heart Disease_______ Sleep Loss_______
Tuberculosis_________ Difficult Breathing____ Diabetes___________ Hemorrhoids______
Cancer______________ Asthma____________ Kidney Disease______ Backaches________
Pneumonia__________ Allergies___________ Liver Disease_______ Nervousness______
Blood Pressure_______ Ulcers_____________ Nerve Disease_______ Headaches________
Diverticulitis__________ Colitis_____________ Urinary Problems_____ Dizziness_________
Bowel Problems_______ Arthritis____________ Sinus______________ Migraines_________

HIV positive: *(yes)* _____ *(no)*_____ Other conditions________________________

Have you been treated for any other health conditions this year? *(yes)* _______ *(no)* _______

What?____

What SURGERY have you had? *Tonsils____ Appendix____ Gall Bladder____ Hemorrhoids____*
Vasectomy ____ Hysterectomy (partial)______ (complete)_____ Other surgery_______________

Have you ever had any bad falls? *(yes)_______(no)_____When?*_______________________________

*Describe:*____

Have you ever broken any bones? *(yes)* _____ *(no)* ___*When?*______________________________

*Describe:*____

Have you ever been in a car accident? *(yes)* ______ *(no)* ______ *When?* _________________________

*Describe:*____

What medications or drugs are you taking?____

List names of other Chiropractors or Naturopaths seen?_____________________________________

Name of person responsible for payment?____

Are you insured? *(no)*___ *(yes)*__ Insurance Co:________________ ID #______________________

Insured name:________________Group #___________________

**Please show your INSURANCE ID CARD to receptionist.*

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that Dr. Peterson will prepare any necessary reports and forms to assist me in making collection from the insurance company. I clearly understand and agree that all services rendered me that my insurance carrier does not cover I am personally responsible to pay. I further agree to a finance charge of 1% monthly on all past due accounts. PAYMENT IS EXPECTED AT TIME OF VISIT.

PATIENT SIGNATURE ____________________________________ DATE______/______/_________

PARENT OR GUARDIAN SIGNATURE____