

STEWART CHIROPRACTIC

Dr. Harold C Stewart JR

PATIENT # _____

DATE _____

PERSONAL INFORMATION

NAME _____ PHONE # _____

STREET ADDRESS _____ PO BOX: _____

STATE _____ ZIP _____

BIRTHDATE _____ AGE _____ SEX _____ SOCIAL SECURITY # _____

MARITAL STATUS: S _____ M _____ D _____ W _____ SEP _____ CHILDREN _____

REFERRED BY _____

ARE YOU PREGNANT? _____

EMPLOYER/OCCUPATION _____ HOW LONG _____

EMPLOYER ADDRESS _____

PHONE # _____

SPOUSE NAME _____ SS# _____

BIRTHDATE _____ PHONE # _____

ADDRESS (IF DIFFERENT THAN YOURS) _____

SPOUSE EMPLOYER _____ HOW LONG _____

SPOUSE EMPLOYER ADDRESS _____

WORK # _____

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STEWART CHIROPRACTIC

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EMERGENCY INFORMATION

NAME OF PERSON TO CONTACT IN CASE OF EMERGENCY: _____

ADDRESS _____

PHONE # _____

NAME OF CLOSEST RELATIVE, NOT LIVING WITH YOU: _____

ADDRESS _____

PHONE # _____

NAME OF A CLOSE FRIEND THAT WE MAY CONTACT WHICH COULD
REACH YOU IN AN EMERGENCY: _____

ADDRESS _____

PHONE # _____

CASE HISTORY

PRIMARY SYMPTOMS _____

DATE SYMPTOMS BEGAN CAUSED BY: _____

ACCIDENT ___ FALL ___ STRAIN ___ OTHER _____

TOTALLY DISABLED FROM _____ TO _____

PARTIALLY DISABLED FROM _____ TO _____

PREVIOUS TREATMENT FOR THIS CONDITION BY: _____

DC ___ DO ___ MD ___ OTHER _____

NAME OF DOCTOR _____ ADDRESS _____

DIAGNOSIS _____ TYPE OF TREATMENT _____ HOW LONG _____

HOW DOES CONDITION INTERFERE WITH NORMAL LIVING/WORK? _____

HAVE YOU HAD SIMILAR SYMPTOMS BEFORE? _____ WHEN _____

DATES OF PAST AUTO ACCIDENTS OR MAJOR INJURIES _____

DATES & TYPES OF PAST SURGERIES _____

HAVE YOU HAD ANY BROKEN OR FRACTURED BONES? _____

SPECIFY _____

LIST PRESENT MEDICATIONS & VITAMINS _____

LIST ANY HEART, LUNG, OR BLOOD PRESSURE CONDITIONS _____

NOTE: I AUTHORIZE THE RELEASE OF ANY INFORMATION NECESSARY TO PROCESS ANY INSURANCE CLAIMS AND ALSO CERTIFY THE ABOVE INFORMATION IS TRUE AND CORRECT. I AUTHORIZE PAYMENT OF INSURANCE BENEFITS TO THIS OFFICE FOR CLAIMS SUBMITTED. I AGREE TO PAY ANY CHARGES NOT PAID BY THE INSURANCE CARRIER.

SIGNATURE _____ DATE _____

STEWART CHIROPRACTIC

Dr. Harold C Stewart JR

CONSENT FOR TREATMENT AND AUTHORIZATION TO PERFORM X-RAYS

DATE _____

I, _____ HAVE BEEN INFORMED BY DR
HAROLD C STEWART, JR, THAT DIAGNOSTIC X-RAYS ARE ADVISABLE IN
MY CASE, SO THAT COMPLETE ANALYSIS CAN BE MADE OF MY PRESENT
MUSCULOSKELETAL PROBLEM (OR ILLNESS).

I AUTHORIZE DR HAROLD C STEWART JR TO PERFORM SUCH
RADIOGRAPHIC EXAMINATION NECESSARY TO DIAGNOSE AND TO
ADMINISTER WHATEVER TREATMENT IS DEEMED NECESSARY TO TREAT
MY PRESENT PROBLEM (OR ILLNESS).

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I, _____ HEREBY NOTIFY ALL CONCERNED,
THAT I NEITHER SUSPECT NOR KNOW POSITIVELY, AT THIS TIME, THAT I
MAY BE PREGNANT. I RELEASE THIS OFFICE FROM ANY AND ALL
DAMAGES ARISING FROM ANY AND ALL PROCEDURES, OF A DIAGNOSTIC
OR TREATMENT NATURE WITH REFERENCE TO THE POSSIBILITY OF
PREGNANCY.

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NOTE: It is understood and agreed that the amount paid STEWART CHIROPRACTIC
for x-rays for examination; only the negatives remain the property of this office, being
available for review while you are a patient here.

**** I authorize the release of any medical information necessary to process any
insurance claim and also certify that the above information is true and correct.

**** I authorize payment of insurance benefits to STEWART CHIROPRACTIC for
claims submitted. I agree to pay any charges not paid by the insurance carrier.

PATIENT'S SIGNATURE _____ DATE _____