NEW PATIENT INFORMATION
EAGLE GROVE CHIROPRACTIC PLC

PATIENT INFORMATION **Date**_____

Name_____
First Middle Initial Last

Social Security Number_____- _____-_____

Date of Birth_____ Age_____ Married S M W D

Address_____

City_____State_____Zip_____

Phone: Home ( )_____ Cell ( )_____ Work ( ) _____

Person to contact in an emergency_____

Phone_____

Person who referred you_____

Employer/ Occupation_____

Spouse or Parents _____

HEALTH INFORMATION

Please state your major complaint_____

Other complaints_____

How long have you had this condition_____

What aggravates your condition_____

Is this condition getting progressively worse_____

List Doctors who have treated this_____

List medication you presently take
_____ nerve pills ____pain killers _____ muscle relaxers
_____ birth control ____insulin _____ blood pressure

Date of last physical examination_____

Have you had a spinal or chest x-ray in the last year? _____ Date_____

PLEASE SEE REVERSE SIDE FOR REMAINDER OF QUESTIONS

OFFICE USE ONLY: Ht:_____ Wt:_____ BP: _____Pulse_____

HEALTH INFORMATION continued: Eagle Grove Chiropractic

Are you suffering from any of the following:

____ loss of taste
____ abdominal pain
____ headaches
____ dizziness
____ loss of smell
____ sinus trouble
____ ear disorders
____ hay fever
____ sore throat
____ chronic cough
____ digestive malfunction
____ allergies
____ insomnia

____ urinary disorders
____ diarrhea
____ constipation
____ menstrual disorders
____ chronic tension
____ irritability
____ sleeping problems
____ bed wetting
____ asthma
____ stomach tension
____ nausea
____ vomiting
____ pregnant _____ last menstrual period

INSURANCE INFORMATION

Does your insurance cover chiropractic?_____

Insurance Company Name_____

Ins. Company Address_____

Ins. Company Phone_____

Policy Holder_____ Birthdate_____

Medicare#_____ Title XIX#_____

I concur with Dr. Parrott that the services he provided to me are "medically necessary." I understand that insurance companies, Wellmark Blue Cross/Blue Shield of Iowa, Medicare and / or commercial insurance companies do not cover or pay for services that they determine to be not "medically necessary" or when services do not meet their predetermined care guidelines (ie: visit limitation's) and therefore may deny payment for the services provided to me by Dr. Parrott. I grant Dr. Parrott and his staff permission to release my records to my insurance company in order to show "medical necessity" for services that I received. I agree to personally pay for services provided to me by Dr. Parrot that are determined to be not "medically necessary" by any insurance company.

I understand and agree that, (regardless of my insurance status), I am ultimately responsible for the balance on my account for any professional services rendered. I have read all the information on both sides of this sheet and have completed the above answers. I certify this information is rue and correct to the best of my knowledge. I will notify you of any changes In my health status or the above information.

I authorize the release of any medical or other information necessary to process this claim.

My signature below verifies that I am consulting Dr. Parrott and giving him authority to diagnose and/or treat my condition, as he deems appropriate.

_____ _____

Patient's or Responsible Party's Signature **Date**