Geipel Chiropractic
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Bolingbrook, IL 60440
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www.geipelchiropractic.com

APPLICATION FOR TREATMENT

PLEASE FILL OUT COMPLETELY

Please mark which number you can be reached at with an X.

NAME:_____ HOME PHONE (____)_____
ADDRESS:_____ CELL #_____
CITY/STATE/**ZIP**_____ E-MAIL_____
EMPLOYER NAME OR SCHOOL_____ CAN YOU BE REACHED AT WORK? Y or N
OCCUPATION_____ WORK PHONE: (____)_____
EMPLOYER ADDRESS_____ CITY/STATE/ZIP_____
BIRTH DATE_____ AGE_____ MARITAL STATUS: S M D W
SOCIAL SECURITY#:_____-_____-_____ NUMBER OF CHILDREN:_____
DRIVERS LICENSE#_____ STATE ISSUED_____
HOW DID YOU HEAR ABOUT OUR OFFICE? _____

****

SPOUSE OR PARENT INFORMATION (RESPONSIBLE PARTY)

SPOUSE NAME:_____ SOCIAL SECURITY #_____
PARENT (If Under 18)_____ SOCIAL SECURITY #_____
ADDRESS:_____ CITY/STATE/ZIP_____

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FINANCIAL

HOW WILL YOU PAYING FOR TODAY'S VISIT? **CASH CHECK CREDIT CARD COUPON**
ARE YOU COVERED BY AN INSURANCE PLAN? **HEALTH AUTO WORK COMP.**
NAME OF INSURED?_____ INSURED'S EMPLOYER_____
INSURANCE CARRIER_____
ADDRESS: _____CITY/STATE/ZIP_____

PLEASE HAVE INSURANCE CARD AND DRIVERS LICENSE READY FOR ASSISTANT TO COPY.

IF APPLICABLE:

ATTORNEY NAME:_____ PHONE NUMBER_____
ADDRESS:_____ CITY/STATE/ZIP_____

****

***PARENTS OF MINORS*—I GIVE PERMISSION FOR _____,D.C. TO EXAMINE AND OR TREAT MY SON/DAUGHTER. SIGN_____**

FEMALE PATIENTS **PLEASE SIGN WHICH APPLIES.**
I VERIFY THAT I AM NOT PREGNANT_____
I AM PREGNANT OR THERE IS A POSSIBILITY I MIGHT BE PREGNANT_____

****

PLEASE BE ADVISED

FEES ARE PAYABLE AT THE TIME SERVICES ARE RENDERED. AS A COURTESY TO OUR PATIENTS, OUR OFFICE WILL BILL YOUR INSURANCE PROVIDED THAT BENEFITS CAN BE OBTAINED BY YOUR CARRIER. A QUOTE OF BENEFITS IS NOT A GUARANTEE OF PAYMENT BY YOUR INSURANCE CARRIER. CO-PAYMENTS WILL BE ESTIMATED FROM THE BENEFIT INFORMATION RECEIVED FROM YOUR CARRIER, AND DUE ON EACH VISIT. OUR OFFICE RESERVES THE RIGHT TO REFUSE TO BILL ANY INSURANCE CARRIER.

OUR OFFICE CHARGES $5-$25 FOR RE-FILING OR SUBMITTING SUBSTANTIAL MEDICAL INFORMATION REQUESTED. THERE IS A $35 FEE FOR ANY CHECK RETURNED FOR NON-SUFFICIENT FUNDS (NSF).

THE PATIENT (OR PARENT OF A MINOR) IS ALWAYS RESPONSIBLE FOR ALL FEES INCURRED. THE PATIENT (OR PARENT OF A MINOR) IS RESPONSIBLE FOR ALL COLLECTION AND/OR ATTORNEY FEES INCURRED IN COLLECTING ANY UNPAID OVERDUE BALANCE. COLLECTION PROCESSING FEE WILL BE 50% OF THE OUTSTANDING BALANCE PLUS THE OUTSTANDING BALANCE.

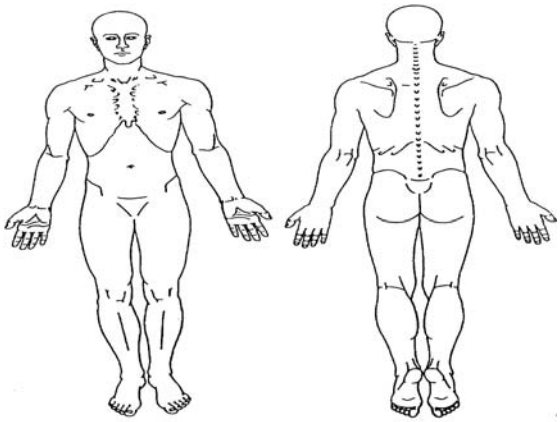
X-RAYS TAKEN AT OUR CLINIC REMAIN THE PROPERTY OF THE CLINIC. COPIES OF ANY FILM MAY BE OBTAINED FOR A FEE.

SIGNATURE_____ DATE_____

Patient Name _____Date _____

About Your Condition

Mark the Exact Location of Pain/Symptom



Describe the pain/symptom, starting with the most severe

1. _____
2. _____
3. _____
4. _____

* *

Circle any of the symptoms you are experiencing:

Headache	Irritability	Numbness in Toes	Face Flushed
Neck Pain	Chest Pain	Shortness in Breath	Buzzing in ears
Neck Stiff	Dizziness	Fatigue	Loss of Balance
Sleeping Problems	Depression	Fainting Spells	Constipation
Back Pain	Loss of Smell	Cold Sweats	Fever
Nervousness	Pins & Needles in Legs	Loss of Memory	Loss of Taste
Tension	Numbness in Fingers	Ears Ring	Diarrhea
Light bothers eyes	Head seems too heavy	Pins & Needles in Arms	Feet Cold
Hands Cold	Other_____		

* *

How did this condition begin? _____

Most **current** date condition/symptoms began?_____

Have you ever experienced a similar problem before? ف No ف Yes

If yes, please give date and explain_____

Have you received any other treatment for this condition? _____

If yes, when, where, and results: _____

Is there anything specific that makes your problem worse? _____

_____

Are you currently taking any medication(s)? _____ If yes, please list below:

_____

Please list any recent surgeries: _____

List any allergies: _____

Is this condition the result of a recent accident? **Yes** **No**

Type of accident: Auto Work Injury Other: _____

Date Occurred: _____Time _____am/pm Location_____

Was the accident reported? Yes No If yes, to whom? _____

Have you reported the accident to your auto insurance or employer? Yes No

Please explain accident in detail _____

_____

If employer related: Employer_____Phone:_____

Full Address_____

If auto accident: (Please circle)

Were you the: Driver Passenger Pedestrian Other_____

Were you struck from: Behind Right Left Front Parked