

MAYSVILLE
1335 South Gate Plaza
Maysville, KY 41056
606-564-4213
800-571-1117
Fax: 606-564-4406

GEORGETOWN
100 Eastside Drive
Georgetown, KY 40324
502-868-0097
800-869-0714
Fax: 502-868-7499

CYNTHIANA
1050 US Hwy 27 South
Cynthiana, KY 41031
859-234-1605
866-789-1605
Fax: 859-234-1628

REPORT OF HISTORY FOR PERSONAL INJURY

VITAL HISTORY

Name: _____ Phone: _____
Email address: _____ Cell Phone: _____
Address: _____ City: _____ State: _____ Zip: _____
Your Social Security #: _____ Birthdate: _____
Spouse Social Security #: _____ Birthdate: _____
Ht.: _____ Wt.: _____ Age: _____ Number of Children: _____ Marital Status: _____
Occupation: _____ Employed by: _____ Phone: _____
Spouse Name: _____ Employed by: _____ Phone: _____
Regular Health Insurance: _____ Secondary: _____
Last Physician: _____ Address: _____
Referred By: _____

AUTO INSURANCE

Your Auto Insurance Co.: _____ Policy #: _____ Agent's Name: _____
Name on Policy (if other than self): _____ Policy #: _____
Responsible Party's Name: _____
Address: _____ City: _____ State: _____ Zip: _____
Policyholder's Name: _____ Policy #: _____

ATTORNEY Yes No (please circle one)

Name: _____ Phone: _____
Address: _____ City: _____ State: _____ Zip: _____
Any witnesses? Yes No Name(s): _____

INSURANCE PATIENTS

Our office does not guarantee that your insurance will pay. We will make every effort, at the beginning of your health care, to receive verification of your policy and its benefits. However, if for some reason, your insurance claim is denied, you are responsible for the full amount of your bill.

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

If my current policy prohibits direct payment to doctor, then I hereby also instruct and direct you to make out the check to me and mail it as follows:

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**I AUTHORIZE PAYMENT OF MEDICAL BENEFITS TO
FAMILY CHIROPRACTIC WELLNESS CENTER
FOR SERVICES RENDERED**

SIGNED (Insured or Authorized Person) _____ Date: _____

Consent To Treatment of Minor Child

I hereby authorize Dr. _____
and whomever he may designate as his assistants to administer
chiropractic care as they deem necessary to my _____
_____ (indicate relationship of child).

Name _____

Date at _____, _____
city state

this _____ day of _____, 20__

Signed: _____
Parent of Guardian

Witnessed: _____

PREGNANCE RELEASE

DATE: _____

I, _____, in signing this
form, state to the best of my knowledge there
is no pregnancy (confirmed or suspected) at
the time this service was rendered.

Patient's Signature

Witness

I hereby certify that the enclosed information is true and answered correctly. I give my consent for examination, x-rays and treatment at the office of Maysville/Georgetown/Cynthiana Family Chiropractic. I agree that if Maysville/Georgetown/Cynthiana Family Chiropractic feels it necessary to have my X-ray's read by an outside radiologist and my insurer fails too, I will accept full responsibility for payment.

I understand that I am responsible for payment to Maysville/Georgetown/Cynthiana Family Chiropractic, and that I will be responsible for any and all collection costs in addition to my bill, that may arise, including collection fees, court costs, and reasonable attorney's fees, should collection action be taken on this bill. Accounts 90 days past due are subject to an interest rate of 1 ½% per month on the unpaid balance.

SIGNATURE _____

DATE _____

WITNESS _____

DATE _____