Dr. Douglas D. Sea
Dr. Trent A. Gusso

Welcome to Our Office!

(Please Print) Date: ____________

Name: ______________________________ Address: ______________________________

City, State, Zip: ______________________________ Home phone: ______________________________

E-mail: ______________________________ Cell phone: ______________________________

Social Security #: ____________ Birthday: ____________ Age: ________ Height: ______ Weight: __________

No. of Children ________ Marital Status – M S D W ______ Spouse's Name or Parent ______________________________

Your Occupation ______________ Employed By ______________ Work Phone: ______________________________

Address ______________________________ City, State, Zip ______________________________

Who may we thank for referring you to our office? ______________________________

Have you ever had Chiropractic Care before? ____________ If so, when? ______________________________

List your complaints in order of severity:

1. ______________________________ For how long? ______________________________

2. ______________________________ For how long? ______________________________

3. ______________________________ For how long? ______________________________

List other doctors consulted for these conditions:

1. ____________________ Address: ______________________________

2. ____________________ Address: ______________________________

Is this injury or illness work-related? ____________ Have you reported it to your employer? ______________________________

Is this injury of illness related to an automobile accident? __________ (if yes, name of)

Your Auto Ins. Co. ____________________ Policy # ____________________ Claim # ____________________

Address ______________________________ Agent's Name ______________________________

NOTICE: Not all patients require x-rays to determine or verify a diagnosis, type of treatment or length of treatment; if your examination warrants X-ray analysis the following office policy prevails: (1) All first visit charges with or without X-rays are payable when service is rendered. (2) The fee paid for treatment X-rays is for analysis only. The film itself is the property of this office and remains part of your permanent records.

Method of payment you plan to use to take care of today's charges:
☐ Check ☐ Cash ☐ MasterCard ☐ Visa ☐ Discover

Major Medical Insurance Co. ______________________________

Group Number ______________________________ I.D. Number ______________________________

Any Other Health Insurance Co. ______________________________

Group Number ______________________________ I.D. Number ______________________________

Medicare ______________________________ Medicare Number ______________________________

Surgery (Please include all surgery)

1.____________________ When ____________________

2.____________________ When ____________________

3.____________________ When ____________________

ARE YOU NOW OR HAVE YOU SUFFERED FROM ANY OF THE FOLLOWING:

Stroke
Fatigue
Migraine
Nervousness
Arthritis
Numbness of pain in arms/legs/hands
Pregnant at this time
Pain between shoulders
Spinal curvature
Heart disease
High blood pressure
Headache
Shingles
Dizziness
Heart attack
Cancer
Diabetes
Sinus
Stiff neck
Backache
Swollen joints

0 ________ 5 ________ 10

Please rate your pain: 0 (Absent) to 10 (Extreme)

Are symptoms
Getting worse   Getting better   Staying the same

X-RAY CONFIRMATION: This is to confirm that I have been advised by this office that x-rays can be hazardous to an unborn child. At this time, to the best of my knowledge, I am not pregnant, and I consent to spinographic pictures.

Signature____________________ Date__________

CONSENT TO TREAT A MINOR CHILD: I hereby authorize this office to administer chiropractic as deemed necessary for my child.

Signature____________________(Parent/Legal Guardian) Date__________

FINANCIAL/INSURANCE POLICY:

I understand and agree that health and accident insurance policies are an arrangement between and insurance carrier and myself. Furthermore, I understand that the Doctor's Office will process any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to the Doctor's Office will be credited to my account on receipt. However, I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment.

Signature____________________ Date__________

AUTHORIZATION TO RELEASE INFORMATION

To: Douglas D. Sea, D.C. / Trent A. Gusso, D.C.

You are authorized to release any information you deem appropriate concerning my physical condition to any insurance company, attorney, or adjuster in order to process any claim for reimbursement of charges incurred by me as a result of professional services rendered by you, and I hereby release you of any consequences thereof.

Signature____________________ Date__________

Witness ____________________