

Gilkey Family Chiropractic & Sports Injury Clinic

Dr. Chris A. Gilkey D.C., A.T.C

Dr. Josh S. Seiler M.S., D.C.

PATIENT INFORMATION

Date: _____ First name: _____ MI _____ Last Name _____ SS#: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Mobile: _____ Marital Status: _____ Date of Birth: _____

Sex: _____ Email: _____ Emergency Contact: _____ # _____

Employer: _____ Occupation: _____ Primary Care Physician: _____

Spouse Name: _____ Employer: _____ SS# _____

Whom may we thank for referring you? _____

INSURANCE INFORMATION

Subscriber's Name: _____ Date of Birth _____ Address: _____

City: _____ State: _____ Zip: _____

Assignment and Release

I certify that I, and or my dependant(s), have insurance coverage and assign directly to Gilkey Chiropractic Clinic all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above-named doctor may use my health care information and may disclose such information to the insurance company (ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services.

(Signature of Patient, Parent, Guardian, or Personal Representative)

(Print name of Patient, Parent, Guardian, or Personal Representative)

(Date)

(Relationship to Patient)

ACCIDENT INFORMATION

Is this condition due to an accident? Yes No Date of accident _____ Type of accident Auto Work Home

To who have you made a report of your accident? Auto Insurance Employer Worker's Comp

HEALTH HISTORY

Please check to indicate if you have had any of the following:

- | | | | | |
|---|--|---|--|---|
| <input type="checkbox"/> AIDS/HIV | <input type="checkbox"/> Bronchitis | <input type="checkbox"/> Gout | <input type="checkbox"/> Miscarriage | <input type="checkbox"/> Rheumatoid Arthritis |
| <input type="checkbox"/> Alcoholism | <input type="checkbox"/> Cancer | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Multiple Sclerosis | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Allergy Shots | <input type="checkbox"/> Chemical Dependency | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Suicide Attempt |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Chicken Pox | <input type="checkbox"/> Hernia | <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Thyroid Problems |
| <input type="checkbox"/> Appendicitis | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Herniated Disk | <input type="checkbox"/> Parkinson's Disease | <input type="checkbox"/> Tumors, Growths |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Eating Disorder | <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Pinched Nerve | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Vaginal Infections |
| <input type="checkbox"/> Bleeding Disorders | <input type="checkbox"/> Fractures | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Prostate Problem | <input type="checkbox"/> Venereal Disease |
| <input type="checkbox"/> Breast Lump | <input type="checkbox"/> Goiter | <input type="checkbox"/> Migraine Headaches | <input type="checkbox"/> Psychiatric Care | <input type="checkbox"/> Whooping Cough |

CONSENT TO TREATMENT OF MINOR CHILD

I hereby authorize Dr. Gilkey/ Dr Seiler and whomever he may designate as his assistants to administer chiropractic care as he deems necessary

to my son/daughter _____ (name of child)

Signed: _____ (name of parent)

Witnessed: _____

Date: _____