Dr. Michael Jefferson 954-825-1004

INFORMATION/APPLICATION FOR CARE

The following information is needed in order to better serve you. Please complete all questions. If you need help please ask the receptionist. (PLEASE PRINT.)

Today's Date ______________

Name __________________________________ Home Phone ______________ Work Phone ______________

Cell Phone _____________________ E-Mail Address ____

Address ________________________________ City ___________________ State ________ Zip __________

Age _____ Birth date ______________________ Marital Status: S M W D Number of Children _____

Please circle one payment type: Cash Check Master Card/Visa American Express

Your Employer ______________________________ Occupation ____________________ Years On Job ____

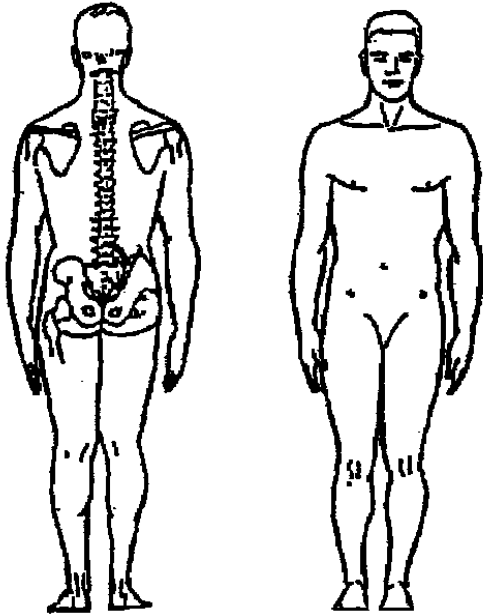
Employer Address _____________________________ City _____________________ State _____ Zip ______

Name of Spouse or Parent ___________________________________ Their Birthdate _______________

Spouse Employed By ____________________________ Occupation __________________Years On Job ____

Employer Address ______________________________ City ____________________ State _____ Zip ______

Office Phone # __________________



COMPLETE THESE DIAGRAMS

If you are in pain, please mark the exact location of your pain on the diagram. Also describe the type and frequency of your pain, as well as any activity which brings on or aggravates the pain. For example; dull, sharp, consistent, off & on, when standing, when sitting, etc………

MAJOR COMPLAINTS

(Please list any condition you are being treated for or are experiencing.)

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____

____

____

____

_

Past Health History (prior surgeries, illnesses, traumas) ____

____

____

Family History ____

____

____

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Do you smoke? ____No ____Yes
If yes, please be specific ____social use _____occasionally _____most of day

Do you drink alcohol? ____No ____Yes
If yes, please be specific ____social use _____occasionally _____most of day

Do you do recreational drugs? ___No ____Yes

I (we) agree to pay for services rendered to the above mentioned patient as the charge is incurred. I understand and agree that health & accident insurance policies are an arrangement between an insurance carrier and myself and that I am personally responsible for payment of any and all services.

Head to Toe Chiropractic does not accept any insurance. I also understand that if I suspend or terminate my care and treatment, any fee for professional services rendered me will be immediately due and payable.

Patient's Signature ____ Date _______________________
Or Guardian Signature ____ Date _______________________

Notice to our new patients: Full payment for services rendered is due at the end of each visit. If for any reason this request cannot be met, arrangements should be made in advance before seeing the doctor.