Pine Belt Chiropractic, Inc.

117 Thornhill Drive ~ Hattiesburg, MS 39402

MyBackHurts.NET

(601) **268-8805**

Patient Name: _____ **Birth Date: _____** **Sex: _____**

Address: _____ **( ) Married** **( ) Not Married**

_____ **Employer: _____**

City **State** **Zip**

Work Address: _____

Home Phone: _____

_____

Cell Phone: _____ **City** **State** **Zip**

SS#: _____ **Work Phone: _____**

Emergency Contact: _____ **Emergency Contact Phone: _____**

Your Method Of Payment: ( ) Cash, Check, Credit Card ( ) Care Credit ( ) Insurance

(“We Will Inform You Of Charges Before Services Are Rendered.”)

I the undersigned, certify that I have Insurance / Third Party coverage with _____ and assign directly to this clinic all Insurance / Third Party benefits for non-negotiable payment in full for all services rendered. I hereby authorize this clinic to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all third party submissions. This shall serve as long-term authorization.

Insurance / Third Party companies say, “Verification Of Benefits Is Not A Guarantee Of Payment.”
I understand that my Insurance / Third Party is an arrangement between myself and my Insurance / Third Party, NOT between this office and my Insurance / Third Party. I understand that if my Insurance / Third Party does not pay within 60 Days, or I suspend or terminate my schedule of care, all fees will be due and payable immediately.

Due to inconsistencies in third party reimbursements all fees charged will be an estimate based on your verification of benefits.

All accounts 90 DAYS LATE collections will be enforced and, the cost of collection services and all fees that apply will be added to your balance. There is an additional 5% capitalized late fee per month on all accounts over 90 days.

_____ **_____**

Responsible Party Signature **Date**

1. **Complaint:** _____

2. **How did it happen: ( ) Don't Know or** _____

   _____

3. **Approximate date this started:** _____

4. **Is this progressively Getting Worse? ( ) No ( ) Yes**

5. **Is Condition: ( ) Constant or ( ) Comes and Goes**

6. **Circle the severity of pain and function, at its worst, on a scale from 1 (least) to 10 (severe pain)**

   1 2 3 4 5 6 7 8 9 10

7. **Have you had this problem before? ( ) No ( ) Yes** _____

8. **Check the type of pain: ( ) Tight ( ) High Pressure ( ) Stiffness ( ) Stabbing**

   ( ) Burning ( ) Sharp ( ) Shooting ( ) Tingling ( ) Numbness

8. **Does your condition interfere with your: ( ) Sleep ( ) Energy ( ) Emotional Stress**

   ( ) Work Activities ( ) Daily Life Activities ( ) Other _____

9. **Activities that are difficult to perform: ( ) Sitting ( ) Standing ( ) Walking ( ) Bending**

   ( ) Lying Down ( ) Rising ( ) Other _____

10. **What treatment have you received for your condition? ( ) None ( ) Surgery ( ) Shots**

    ( ) Drugs ( ) Physical Therapy ( ) Chiropractic ( ) Other: _____

11. **Name of medical practitioner who has treated you for this condition?**_____

12. **Have you ever been to a chiropractic Doctor? ( ) No ( ) Yes – Last adjustment** _____

13. **Drugs You Are Taking:** **Reason For Taking:**

    _____ _____

    _____ _____

    _____ _____

14. **Who May We Thank For Referring You To Our Clinic?** _____

"Welcome To Our Clinic!"