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Patient Number

Today's Date

CONTACT INFORMATION

Name	$ Preferred to be called _ \Box Male \Box Female $			
Address	City	State	Zip	Birth Date:
Home Phone				
Preferred Method of Communication(circle one): Email / Phone / Mail				
E-mail	SSN	Who Refer	red you to t	his office?
Primary Doctor	Marital Status: S M D W SPOUSE'S NAME			
ë ë <u>–</u>	Race: American Indian _Decline to SpecifyOther Race_			
Occupation	Emplo	yer		
Emergency Contact	Phone Nu	mber	R	elationship

BILLING INFORMATION

Do you have medical insurance?	□Yes □ No Insura	ance Company Name	
Insured's Name	Relationship to patient		
Insured's DOB	Insured's SS#		
Insured's Employer	Insured's E	Employee Address	
Do you have a secondary insurance? ? Yes No Insurance Company Name			
If you are not financially respon	nsible for your acco	ount, who is?	
Name:		Phone:	
Address:			

I authorize RIVER RIDGE CHIROPRACTIC to release any information pertinent to my case to my insurance carrier and to submit a claim for all services rendered by this office. I authorize and direct my insurance carrier or its intermediaries to issue payment checks directly to this office for services rendered. I understand I am financially responsible to this office for any balance not covered by this authorization. I understand that if I suspended or terminate my care and treatment, any fees for professional services rendered me will be immediately due and payable. If it is ever necessary for this office to employ collections counsel, I understand that I am responsible for those collection charges. A copy of this signature is as valid as the original. Date

Patients Signature

0		•
Guardian or Spouse's Signature	D	late

CHIROPRACTIC HISTORY

Have you ever been to a Chiropractor before? Set Yes	No If yes Doctor's Name
Date of last chiropractic visit	Reason for Care
Date of last x-rays	How long were you under care?

HEALTH HISTORY

Check any symptoms/medical conditions that you have had: $\Diamond = Previously$, $\Box = Now$

- ♦ □ Headaches/Migraines
 ♦ □ Memory loss/problems
 ♦ □ Thyroid problems
 ♦ □ Thyroid problems
 ♦ □ Thyroid problems
 ♦ □ Alcohol/Drug Abuse
 ♦ □ Alcohol/Drug Abuse
 ♦ □ Neck pain or stiffness
 ♦ □ Trouble with balance or
 ♦ □ Shoulder pain

 Indext pain or stiffness
 Invest pain or stiffness
 Invest pain or stiffness
 Invest pain or stiffness
 Invest pain or cough
 Invest pain List all medications/supplements/controlled substances you are taking. List any medication allergies you have.

List any other serious medical conditions that you have ever had:

List all surgical operations and years:

List all serious accidents with dates: (motor vehicle accidents, falls, spills or broken bones)

CURRENT HEALTH CONDITION

What is your major complaint?_____

How long have you had this condition?

Have you had this or similar conditions in the past?

What activities aggravate your condition?

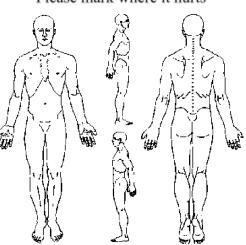
Is this condition getting progressively worse? \Box Yes \Box No

 \Box Constant \Box Comes and goes

Is this condition interfering with your:

□ Work □ Sleep □ Daily Routine □ Other:

Other doctors who treated this condition:



Please mark where it hurts