File #:_____

BLAINE CHIROPRACTIC CENTER

11919 Central Ave NE
Blaine, MN 55434-3911
Phone: (763) 757-1660
Fax: (763) 757-4108
blainechiro.com

Thomas C. Rice, D.C.
Rebecca J. Rice, D.C.
Michael T. Hample, D.C.
Ezra C. Schlotthauer, D.C.

Please print legibly. Thank you! DATE: _____

NAME:_____ PHONE: _____
First Initial Last
ADDRESS: _____ CELL: _____
_____ ZIP: _____-_____
City State Last Four Digits
DATE OF BIRTH: _____ E-MAIL: _____
AGE: _____ SEX: M F MARITAL STATUS: S M D W O # OF CHILDREN:_____
OCCUPATION: _____ EMPLOYER: _____
WORK PHONE: (___)_____ ADDRESS: _____
City State Zip
PERSON RESPONSIBLE FOR THIS ACCOUNT: _____
NEAREST RELATIVE: _____ PHONE: (___)_____
ADDRESS: _____
City State Zip
REFERRED BY: _____

Race/Ethnicity: White_____ American Indian/Alaskan Native_____ Asian_____
Native Hawaiian/Other Pacific Islander _____ African American_____ Hispanic/Latino_____ Decline to Answer

SPOUSE INFORMATION: _____
First Name Initial Last
SPOUSE EMPLOYER: _____ PHONE: (___)_____
SPOUSE OCCUPATION: _____ ADDRESS: _____

TYPE OF INSURANCE COVERAGE (Please Check one):

[ ] No Insurance: Cash Payment _____ Weekly _____ Biweekly _____ Monthly____

[ ] Major Medical Insurance: Policy Holder Name: _____
Insurance Company Name: _____ Policy#_____
Address: _____
City State Zip

[ ] Worker's Compensation: Date of Injury: _____ Time:_____
Employer at time of injury: _____
Address: _____
City State Zip

[ ] No-Fault Auto Accident Coverage: Policy Holder: _____
Insurance Company Name: _____
Address: _____
City State Zip
Claim # _____ Insurance Adjuster Name: _____

HEALTH, ACCIDENT & SYMPTOM INFORMATION

What is your major complaint? _____

Other complaints: _____

How long have you had this condition? _____

Date of recent falls or accidents? _____

Please describe accident related to your condition: _____

_____

List other doctors that have treated you for this condition/accident: _____

_____ Date(s): _____

List all surgical operations: _____

_____

List all medications you are presently taking: _____

_____

Check below all symptoms you are currently experiencing:

[ ] Headaches	[ ] Dizziness	[ ] Light hurts eyes	[ ] Diarrhea
[ ] Neck pain	[ ] Head seems heavy	[ ] Loss of Memory	[ ] Feet Cold
[ ] Neck stiffness	[ ] Pins/needles in arm	[ ] Ears ring	[ ] Hands cold
[ ] Sleep problems	[ ] Pins/needles in leg	[ ] Face flushed	[ ] Stomach upset
[ ] Back pain	[ ] Numbness in fingers	[ ] Buzzing in ears	[ ] Constipation
[ ] Nervousness	[ ] Numbness in toes	[ ] Loss of balance	[ ] Cold Sweats
[ ] Tension	[ ] Shortness of breath	[ ] Fainting	[ ] Fever
[ ] Irritability	[ ] Fatigue	[ ] Loss of smell	
[ ] Chest pain	[ ] Depression	[ ] Loss of taste	

Additional Symptoms: _____

_____

Family Health Information:

Name: Relation: Past & Present Health Problems:

_____

_____

_____

I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. This office will submit claims to the appropriate insurance company at no extra charge to me. Should they deny payment, I am still responsible for the unpaid balance.

I consent to the release of information about my medical condition to any health care provider involved in current treatment related to this visit or episode of care. I further consent to the release of my health information to any insurance company, health plan, or government payer for the purpose of processing payment for services, including the determination of benefits. I understand that I may revoke this consent in writing at any time, but my revocation will not apply to information that has already been released.

By signing below, I also acknowledge that I have received our Notice of Privacy Practices.

Patient Signature: _____

Parent/Guardian Authorizing Care: _____ **Date:** _____