



Patient Update Form

Welcome Back to **Ancala Chiropractic**. We are so happy you're here. Please take a few moments to update your records. Thank you.

Please **answer ALL the questions in detail** to the best of your ability. (All information you give is confidential)

UPDATED PERSONAL INFORMATION

Today's Date: _____

Name: _____ Female Male **Social Security No.** _____ / _____ / _____
(for insurance verification purposes)

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

Home No. (____) _____ Cell No. (____) _____ Work No. (____) _____

Date of Birth: _____ / _____ / _____ Age: _____ Height: _____ ft _____ in Weight: _____

Minor Single Married Separated Divorced Widowed Partnered for _____ years Name of Spouse: _____

Number of children _____ Name: _____ age: _____ / Name: _____ age: _____ / Name: _____ age: _____
/ Name: _____ age: _____ / Name: _____ age: _____ / Name: _____ age: _____

Current Occupation: _____ Employed by: _____

Complete e-mail address: _____ @ _____ . _____

IN CASE IF EMERGENCY, CONTACT

Name _____ Relationship _____

Home No. (____) _____ Cell No. (____) _____ Work No. (____) _____

YOUR CURRENT HEALTH CONDITION

1. My Present symptoms are: _____

2. Recent Falls: _____

3. Recent Surgery: _____

4. Last Physical: _____

5. Last Adjustment: _____

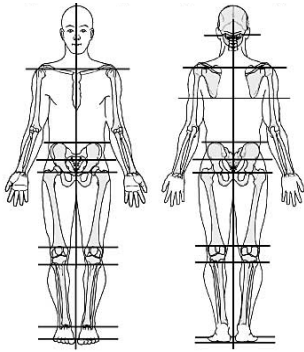
6. Since Your Last Visit To Our Office, Who as the Last Dr. You Saw and for What Condition? _____

7. Have You Been in a Recent Accident? Yes No

Since Your Last Treatment By Us? Yes No **(Note: If this is an auto accident claim, we have additional paperwork for you to fill out)**

Please List Details: _____

8. Is There Any Information We Should Know Concerning Your Return To Us or That You Would Like To Share With Us? _____



IMPORTANT...Please fill out!

Circle where you hurt and put the letter of how you feel NEXT to it.

On the diagram, please circle where you are experiencing ALL of your present complaints using the following letters:

- A: ache B: burning pain C: cramping
 D: dull pain N: numbness R: throbbing pain
 T: tingling O: other _____

BILLING

If you have insurance, we need an updated copy of your insurance card.

Who is responsible for this account? YOU and... Cash Workers Comp Auto Injury Medicare Personal Health Insurance Parent

Primary Health Insurance Information (you do not need to fill this out if we make a copy of your insurance card.)

Insurance Company Name _____ Member Services Phone # (_____) _____ - _____
 Policy # _____ Group# _____ Name of Insured _____

If someone else other than patient please fill out the following:

Name: _____ Female Male Social Security No. _____/_____/_____

Date of Birth: ._____/_____/_____

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

Home No. (____) _____ Cell No. (____) _____ Work No. (____) _____

PAYMENT IS EXPECTED AT TIME OF VISIT

ASSIGN AND RELEASE & CONSENT FOR TREATMENT

I certify that if I, and/or my dependent(s), have insurance coverage I assign directly to Dr. Mitchell Borst and , 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 understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. I authorize the use of my signature on all insurance submissions.

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

I, the undersigned, a patient in this office, hereby authorize/consent Dr. Mitchell Borst, DC, , Ancala Chiropractic, Desert Ridge Chiropractic, New Beginnings Chiropractic, their associates or interns (and whomever he may designate as his assistant(s) to administrator treatment as necessary). I also certify that no guarantees or assurances have been made to me as to the results that may be obtained.

I also authorize Dr. Mitchell Borst and to give chiropractic in an "open-door", adjusting environment, and can use my name on welcome boards, referral boards, sign-in sheets, and travel file use. I understand it is the desire of this office to provide chiropractic care in an "open-door" adjusting environment. An open-door approach involves the doctor moving from patient-care area to patient-care area. As a result, patients and patient files with patient names are within sight of one another and some ongoing routine details of care are discussed within earshot of other patients and staff. This environment is used for ongoing care and is NOT the environment used for taking patient histories, performing examination of present reports and findings. These procedures are completed in a private, confidential setting. I also understand e-mail address will not be sold to anyone but used only from their office for their newsletter, office news or contact purposes. I also authorize this office to pre-approve me for payment arrangements through CareCredit® by the use of my name and address only, which will *not* affect my credit report or credit score.

I also understand that if I suspend or terminate my care and treatment, and fee for professional services rendered to me will be immediately due and payable to Ancala Chiropractic, Desert Ridge Chiropractic, and New Beginnings Chiropractic. If my account goes to collections I am responsible for any and all collection fees. I have read the above information and certify it to be true and correct to the best of my knowledge, and hereby authorize Ancala Chiropractic, Desert Ridge Chiropractic, and New Beginnings Chiropractic to do whatever is necessary in accordance with this state's statutes, to provide me with chiropractic care.

Patient's Signature: _____

Date: _____

Guardian or Parent's Signature: _____

Date: _____