

**Manassas Spine and Sport
9210 Lee Ave.
Manassas, VA 20110**

Confidential Patient Information

Patient's Information

Name: _____ Date: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Phone: (Home) _____ (Work) _____ (Cell) _____

Email: _____ Referred By: _____

Age: _____ Birth Day: _____ Social Security #: _____

Sex: Male Female Martial Status: Single Married Widowed Divorced

Employer's Information:

Occupation: _____ Position: _____

Employer Name: _____ Phone: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Name and Address of Closest Relative Other Than Spouse (Not At Above Address)

Name: _____ Phone: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Relationship to Patient: _____

Spouse's Information

Name: _____ Phone: _____

Spouse's Employer's Information:

Occupation: _____ Position: _____

Employer Name: _____ Phone: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Other Information

If this is an accident:

Date of Accident: _____ Work Related: Yes No Auto Related: Yes No

Are You Represented By An Attorney? Yes No

If So, Who IS Your Attorney?

Name: _____ Phone: _____

Street Address: _____

City: _____ State: _____ Zip: _____

X-Ray History: (Include Cat, Mir, Dye Studies and Dental)

When Was Your Most Recent X-Ray/Other Study? _____

Present Symptoms: _____

Have You Been In Any Recent Accidents? ___Yes ___No

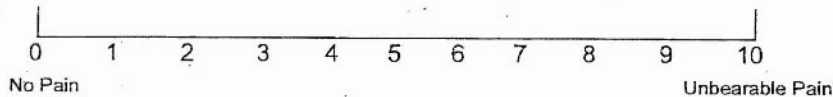
If Yes, Please Explain: _____

Has Your Insurance Coverage Changed Since Your Last Visit? ___Yes ___No

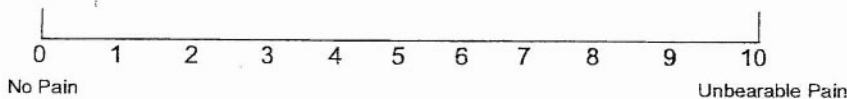
*If yes, please give your insurance card to the receptionist to be copied.

1. How do you feel today?

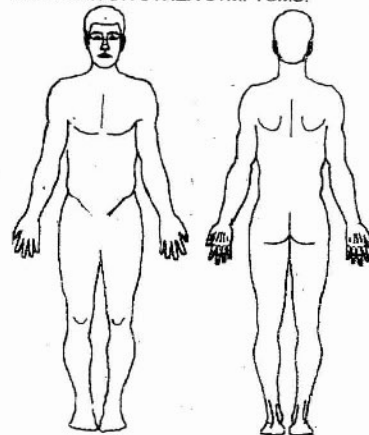
Current complaint:



Average pain level over the past week:



MARK AN X ON THE PICTURE WHERE YOU HAVE PAIN OR OTHER SYMPTOMS.



2. Is there anything new?

Have you had any new complaints/conditions since starting care? No Yes

Have you had any re-injuries or events that have prolonged your recovery? No Yes

Explain: _____

FINANCIAL AGREEMENT AND INSURANCE ASSIGNMENT

I hereby authorize treatment to patient by the above Doctor of Chiropractic, and/or any affiliated staff member(s). I hereby authorize release of any and all medical and/or charge information as is necessary for third party reimbursement from my insurance carrier or Medicare. I authorize direct payment from said insurer(s) to this practice. I accept responsibility for payment of all charges incurred as well as attorney's fees of 33 1/3% and any other related costs of collection should such action become necessary. If bill is not paid when tendered, it shall bear interest at the rate of 18% per annum.

DATE _____ PATIENT/GUARANTOR _____ RELATIONSHIP TO PATIENT _____