Coastal Medical and Wellness Center

New Patient Information

Name _____ ☐Female ☐Male Date _____

What you prefer to be called _____ Age _____ Date of birth _____

Preferred Language ☐English ☐Other _____ Race: ☐White ☐African American ☐ Other _____

Address _____ City _____ State _____ Zip _____

Home Phone _____ Cell Phone _____

Email Address _____ SS# _____

Preferred Method of Contact _____

Employer _____ Occupation _____ Work Phone _____

Emergency Contact _____ Relation _____ Phone _____

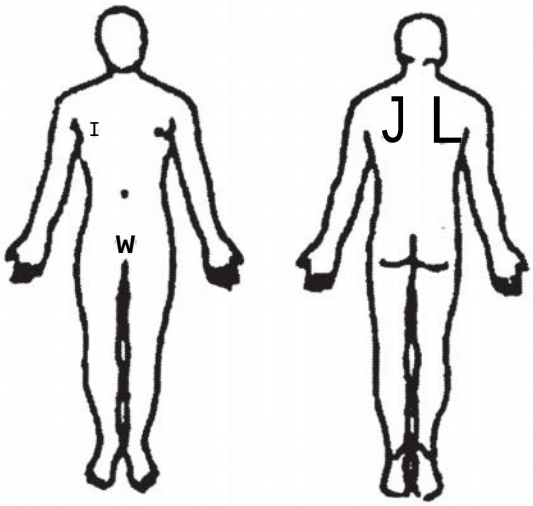
How did you hear about our office? _____

When did your condition begin? _____

Other Doctors seen for this condition? _____

Have you had the same or similar symptoms before? ☐ Yes ☐ No Date of prior condition _____

Mark Areas of Pain on Figures Below



List chief symptoms in order of severity:

(1) _____

(2) _____

(3) _____

Have you had chiropractic care before? ☐ Yes ☐ No

Family Physician _____

May we forward our findings to your doctor? ☐ Yes ☐ No

Current Medications _____

_____

_____

_____

Allergies (Medicine, Food, Environment) _____

_____

Previous Surgeries _____

Do you have a PERSONAL history of: ☐ Cancer ☐ Diabetes ☐ Heart Disease ☐ Stroke

Other serious illnesses _____

Check all symptoms that apply to you:

☐ Headache	☐ Tingling/numbness in arms/hands	☐ Chest Pain	☐ Unexplained weight loss
☐ Neck Pain/Stiffness	☐ Tingling/numbness in legs/toes	☐ Knee Pain	☐ Fatigue
☐ Back Pain/Stiffness	☐ Loss of balance/dizziness	☐ Hip Pain	☐ Night Sweats
☐ Shoulder Pain	☐ Shortness of breath	☐ Fever	☐ Blood in Urine
☐ Other _____		☐ Night Pain	☐ Pain unrelieved by rest

For women: Are you pregnant? ☐ Yes ☐ No Are you taking birth control? ☐ Yes ☐ No

Health Insurance

Policyholder Name _____Date of Birth _____

Workers Compensation

Is your condition due to an Employment Related Injury? Yes ☐ No ☐ Have you reported it? Yes ☐ No ☐

Date of accident _____

Supervisor _____ Supervisor # _____

Auto Accident

Is your condition due to Automobile Accident? Yes ☐ No ☐ Date of accident _____

Auto Accident Insurance Name _____ Claim # _____

Adjuster Name _____ Phone #_____

Attorney Name _____ Phone #_____

INSURANCE INFORMATION, CONSENT OF PROFESSIONAL SERVICES AND RELEASE OF INFORMATION

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore I understand that this office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to this office will be credited to my account on receipt. However, I clearly understand and agree that all services rendered to me are changed directly to me and that I am personally responsible for payment. I also understand if I suspend or terminate my care and treatment, any fees for professional services rendered to me will be immediately due and payable.

I hereby authorize Dr. Pearson, Dr. Atwell and their affiliated providers to administer treatment, physical examination, X-ray studies,laboratory procedures, chiropractic care, physical therapy, or any clinic services that they deem necessary in my case; I do hereby give my consent for the performance of conservative non-surgical treatment, including, but not limited to manipulation, physical therapy modalities, soft tissue massage and therapeutic exercises. I am aware there are possible risks and complications associated with these procedures, ranging from soreness to stroke. I understand there is no certainty that I will achieve benefits and acknowledge that no guarantee has been made regarding the outcome of these procedures. I am aware there are alternatives to these procedures, including medication and/or surgery. I further authorize them to disclose all or any part of my (patient's) record to any person or corporation which is or may be liable under a contract to the clinic or to the patient or a family member or employer of the patient for all or part of the clinic's charge, including, and not limited to hospital or medical services companies, insurance companies, workers compensation carriers, welfare funds, or the patient's employer.

I understand that if an insurance company initially pays for my treatment and later requests reimbursement from CMWC for any reason, I will be responsible for payment of my entire outstanding balance.

We invite you to discuss any questions you might have with us. The best health services are based on a friendly mutually understood relationship.

Patient's or Guardian's Signature _____Date _____

CONSENT TO TREAT A MINOR

I (we) being the parent, guardian or custodian of the minor being _____, age _____, do hereby authorize, request & direct CMWC, it's doctors and staff to perform examinations, diagnostic x-rays, laboratory tests, and any treatment that in their judgment, is deemed advisable or required.

It is the understanding of the undersigned that the physicians and their staff will have full authority from me as legal parent/guardian to continue with examinations, diagnostic tests, and treatments as will be needed while said minor shown above is under care in this office until legal age is attained.

As legal parent/guardian, I realize full responsibility for all charges and payments due.

Parent/Guardian or Custodian Signature _____ Date Signed _____

Witness _____