STEP 4 IN EVENT OF EMERGENCY

Who Should We Contact: _____

Relation: _____

Home Phone#:_____Work Phone #_____

Who is your Medical Doctor? _____ Phone #:_____

STEP 5 HEALTH ISSUES

Are you taking any of the following medications?

_Nerve Pills _Pain Killers (Including Aspirin) _Muscle Relaxers_
Stimulants _Blood Thinners _Tranquilizers _Insulin _Other_____

Do you have or ever had any of the following diseases or conditions?

Y N Heart Attack/Stroke	Y N Heart Surg/Pacemaker	Y N Heart Murmur
YN Congenital Herut Defect	YN Mitral Valve Prolapse	Y N Artificial Valves
Y N Alcohol/Drug Abuse	Y N Venereal Disease	Y N Hepatitis
Y N Hiv + / AIDS	Y N Shingles	Y N Cancer
YN Frequent Neck Pain	YN Emphysema / Glaucoma	Y N Anemia
YN High/Low Blood Pressure	YN Psychiatric Problems	Y N Rheumatic Fever
YN Severe/ Frequent Headaches	YN Kidney Problems	Y N Ulcers / Colitis
YN Fainting/Seizures/Epilepsy Y	YN Sinus Problems	YN Asthma
YN Diabetes/Tuberculosis	Y N Difficulty Breathing	Y N Chemotherapy
YN Lower Back Problems	YN Artificial Bones/Joints	Y N Arthritis

Please list any other serious medical condition(s) you have or ever had: _____

_____

Please list anything that you may be allergic to:_____

List previous surgeries/treatments with dates:_____

List any past serious accidents with dates:_____

Family Health History: _____

Do You: Take Supplements for Vitamins: _Yes _No/ Exercise __Yes __No

Are you on a special diet: _Yes _No/ Since: ____/__/____

Do you smoke? _No_Yes / How much?_____ How Long?
Are you wearing: _Heel Lifts _Sole Lifts _Inner Soles _Arch Supports_____
What is the age of your mattress?____Is it comfortable? _Yes _No
For Women: Are you taking Birth Control? _Yes _No
Are you Pregnant? _ No _Yes/How Long? Nursing? _Yes D No

STEP 6 ACCOUNT INFO

Persons ultimately responsible for

Name: _____

Relation: _____

Billing Address: _____

_____
City State Zip

SSN: _____

D.L.#_____

Work Phone #:
Payment Method: CASH Check _____

_____
Credit Card -Enter Card # Above (if accepted)

I hereby authorize assignment of my Initial insurance rights and benefits directly to the provider for services rendered. I fully understand I am solely responsible for any balance not paid by my insurance company.

NOTIFICATION

- We invite you to discuss with us any questions regarding our services. The best health services are based on a friendly mutual understanding between provider and patient
- Our policy requires payment in full for all services rendered at the time of visit, unless other arrangements have been made with the business manager. If account is not paid with 90 days of the date of service and no financial arrangements have been made, you will be responsible for legal fees, collection agency fees, and any other expenses incurred in collecting your account.
- I authorize the staff to perform any necessary services needed during diagnosis and treatment. I also authorize the provider and or managed care organization, to release any information required to process insurance claims.

•Iundertand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes to the information I have provided.

Signature _____ Date___/__/____

Adult Patient Parent or Guardian Spouse