Aaron's Plaza
1111 Oakdale Road, Suite #1
Oakdale, PA 15071
Phone: (412) 787-0101

About You

Please complete all information accurately. This form has interactive fields that allow you to complete it electronically. Please make sure all questions are answered. Please TYPE or PRINT legibly and bring this form with you to your first visit. Thank you.

PERSONAL INFORMATION

Full Name:______________________ Age:__________Birthday:_____/_____/_____
Address:______________________ City:______________State:_______ Zip:____________
Telephone # (Home):______________ (Work/Cell):______________ Sex: ❑ MALE ❑ FEMALE
E-Mail Address:______________________ (Used for office hour changes, closings, and announcements.)
Marital Status:____________ Spouse's Name:______________ Spouse's Birthday:_____/_____/_____
# of Children:________ Name(s):______________________
Are you pregnant? ❑ Yes ❑No

How did you first hear about Doctor V? (Who referred you?) ______________________

What are your hobbies/interests? ______________________

I prefer to receive mail in the following manner: ❑ Postal Mail ❑ e-Mail ❑ Both

Your Occupation:______________________ Employer Name:______________________
What does your work involve? Please explain your duties:______________________

HEALTH CONCERNS

Are you interested in health maintenance and/or wellness care? ❑ YES ❑ NO

What is the reason you are seeking chiropractic care?______________________
How long have you been living this way? ______________________
What caused this concern?______________________
What do you feel is holding you back from being healthy? Please explain:______________________
Do you have a family medical doctor? ❑ YES ❑ NO
Have you been seen by a medical doctor for any reason in the last year? ❑ YES ❑ NO If yes, for what reason? ______________
Please list any surgeries, falls, accidents, or injuries?
______________________ Date:____________ ______________________ Date:____________
______________________ Date:____________ ______________________ Date:____________

Are you aware of any birth complications of your own? (i.e. forceps, caesarean, etc.)______________________

Have you received chiropractic care before? ❑ YES ❑ NO If yes, when was your last visit?______________________

LIFESTYLE

Instructions: Rate each of the following. This lifestyle information is necessary in order to give you a customized program of care.

Your diet (Poor, Good, or Excellent): ____________
Your rest (Poor, Good, or Excellent): ____________
Your exercise regularity (Poor, Good, or Excellent): ____________
How is your level of stress on a scale of 1 to 10 with 10 being the **HIGHEST** level of stress? ______

I agree that the information provided on this form is complete, true, and accurate to the best of my knowledge. I also understand that the recommendations I receive will be Lifestyle-Based® and are designed to assist in my overall health and productivity. Parent or guardian must sign for children under 18 years of age.

Please sign here: ✘______________________ Date:____/____/____

Parent/Guardian Name:______________________ Relationship:______________________

Updated 9/17/2014

Name(s): ______________________________ **Today's Date:** ____________________

Terms of Acceptance & Practice Objective: Consent for Chiropractic Care

When a person seeks the services of a chiropractor it is absolutely essential to fully understand the objectives of that particular chiropractor.

It is not the goal or intention of this office or any of its staff to diagnose, treat, or attempt to cure any physical, mental or emotional ailments, or to give advice about any ailments.

The only objective of this office is to keep the body as free as possible from vertebral subluxations. Vertebral subluxations are misalignments of spinal bones that alter nerve system function. Vertebral subluxations prevent the body from attaining higher levels of performance and reaching your potential in, not only health, but also, in other areas of your life. Subluxations are caused by many of the things you do **everyday** and keep your **whole** body from functioning at its full potential.

It is our absolute conviction that a body is better able to live up to its full potential and adapt better to your lifestyle, thereby enhancing your health and maintaining a higher level of health when no subluxations are present and for no other reason.

The information we receive from you is important. We ask only that which is necessary for your care here at Doctor V Chiropractic Center, Inc. Please fill out the forms completely and to the best of your ability. If you have any questions or if there is any information you feel we should know, please mention it to the chiropractor.

I____________________ & ____________________ ______________________ undertake chiropractic care for ourselves and our family on the understanding of and agreement with, the above practice objective.

Signature: ✘ ______________________________ Signature: ✘ ______________________________

Authorization To Release Chiropractic Information

I authorize Doctor V Chiropractic Center, Inc. to release information pertinent to my care in order to receive reimbursement for the cost of services rendered to me. This authorization includes insurance companies, collectors, attorneys, etc. and shall remain valid as long as there is a balance owed on my account.

Signature: ✘ ______________________________

Assignment of Benefits and Intent to Pay

If I choose to use insurance to assist me in paying for my chiropractic care in this office, I assign my benefits and authorize direct payment to Doctor V Chiropractic Center, Inc. and/or Robert J. Vano, D.C. the benefits allowable and otherwise payable to me under my current policy. I have agreed to pay, in a current manner, deductibles and co-payments. Returned checks or declined credit cards will incur a $30 service fee. I understand that, if collections actions become necessary for the payment of any balance owed this office that I will be responsible for the payment of any attorney fees and collection fees that are acquired as a result of this collection action. I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment and overdue balances will incur interest charges of 1.5% per month (18% per year).

Signature: ✘ ______________________________

Attorney's Protection of Balance (PI & WC Only)

I am directing my attorney, ______________________________, to pay any outstanding bills out of my settlement and, in effect, protecting any such balance. I hereby make and declare the instructions herein contained to be irrevocable. I fully understand that I am directly responsible for payment of all bills for services rendered to me and this agreement is made solely for the Doctor V's Chiropractic Center, Inc.'s additional protection and consideration of them awaiting payment. I further understand that such payment is not contingent on any settlement, judgment or verdict by which I may eventually recover said fee. I have been advised that if my attorney does not wish to cooperate in protecting the doctor's interest, the doctor will not await payment but, will require me to make payment on a current status.

Signature: ✘ ______________________________

Chiropractic Records Release

I authorize the release of my Chiropractic Records from Doctor V Chiropractic Center, Inc. I understand there may be a fee charged to myself for records gathering, copies, and shipping charges and I agree to be responsible for payment prior to the records being released. Please forward to:

Name: ______________________________ Address: ______________________________

Signature: ✘ ______________________________