Heartland Chiropractic Clinic, PC
Thomas L Smith, DC
2418 Cornhusker Road
Bellevue, NE 68123 402-291-2121

Number_____

Date_____

Name_____Referred by_____

Address_____City_____State_____ZIP_____

Date of birth_____ Marital Status: Single Married Divorced Other

Phone: Home_____ Cell_____ Email_____

Social Security Number_____Occupation_____

Employer_____ Phone Number_____

Spouse's Name_____ Spouse's Date of birth_____

Spouse's Employer_____ Phone Number_____

Whom to Contact in Emergency_____Phone_____

Name of Insurance Company_____

Policy Holder's Name_____ Relationship to patient_____

Have you ever had chiropractic care before? _____

Who have you seen already for this problem? _____

What is your primary complaint? _____

_____

_____

Is it constant, or does it come and go? _____

Are you improving, same, or worse? _____

What aggravates the problem? _____

Have you ever had a similar condition? _____

Can you think of anything that may have caused this? _____

What have you done so far to treat this? Did it help? _____

What normal activities has this interfered with? _____

How would you rate your health? Excellent Good Fair Poor

Do you smoke? Yes No Used to but quit

What surgeries have you had? _____

_____

Other hospitalizations_____

_____

Do you have any other health diagnoses, such as diabetes or high blood pressure? _____

_____

Do you have cancer or have you had cancer, and what type? _____

Do you have any other health concerns? _____

_____

Please list any medicines you are currently taking. _____

_____

What concerns do you have about treatment here at our office? ____ Cost ____ Insurance coverage

___Length of treatment _____ Comfort of treatment ____ Other

Please fill out the following if this is related to an auto accident or on-the-job injury.

Have you reported this accident or injury to your supervisor or insurance company? _____

Date, time, and place of accident/injury_____

Please describe the accident in your own words_____

_____

What symptoms did you have after the accident? _____

_____

Patient or Authorized Person's Signature: I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below. I authorize payment of medical benefits to the physician for services. I understand that regardless of my insurance status, I am ultimately responsible for the balance on my account for professional services rendered. I have read all the information on both sides of this sheet and have completed the answers. I certify that this information is true and correct to the best of my knowledge.

Signature_____ Date_____

Parent if minor _____Date_____