

**PLEASE PRINT**

Purpose of this appointment (Major Complaint) \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

What activities aggravate your condition? \_\_\_\_\_  
Is this condition getting progressively worse?  Yes  No  Constant  Comes and goes  
Is this condition interfering with your:  Work  Sleep  Daily Routine  Other \_\_\_\_\_

How long has it been since you really felt good? \_\_\_\_\_  
What do you believe is wrong with you? \_\_\_\_\_  
Other Doctors seen for this condition \_\_\_\_\_

Have you been treated for any health conditions by a physician in the last year  Yes  No  
Describe \_\_\_\_\_

What medications or drugs are you taking? \_\_\_\_\_  
Remarks and additional information \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**PAYMENT IS EXPECTED AT TIME OF VISIT!**

Name of person responsible for payment \_\_\_\_\_  
Are you insured?  Yes  No Company \_\_\_\_\_

*I understand that payment is required at time of service. Most medical insurance and some credit cards are accepted. I understand and agree that health accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that this chiropractic office will prepare any necessary reports and forms to assist me in making collections from the insurance company and that any amount authorized to be paid directly to this chiropractic office will be credited to my account on receipt. I also give this office power of attorney to endorse checks made out to me, to be credited to my account. However, I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered me will be immediately due and payable. I further agree to pay all collection agency fees, attorney fees, court fees and other related costs incurred in the collection of my account.*

*I authorize the release of medical records to the physician or physicians to whom I may be referred. I authorize the release of any medical information necessary to process insurance claims.*

I authorize payment of medical benefits to *Dr. Colin W. Frogley*

Patient Signature \_\_\_\_\_ Date \_\_\_\_\_  
Guardian or Spouse's Signature Authorizing Care \_\_\_\_\_ Date \_\_\_\_\_  
Information Taken by \_\_\_\_\_ Date \_\_\_\_\_

COMMENTS: \_\_\_\_\_  
\_\_\_\_\_