Vance Clinic of Chiropractic

Doctor _____

Date _____

Payment _____ Cash, Check
Credit Card
Insurance

CONFIDENTIAL PATIENT ADMITTANCE FORM – PLEASE PRINT

Name _____ Wife, Husband or Guardian _____

Address _____ (City) (State) (Zip)

Marital Status _____ Circle one -male -Female Birth Date _____ Number of Children _____

Home Phone Number _____ Work Phone Number _____ Social Security Number _____

Height _____ Weight _____ Pregnant _____ Occupation _____

Employer _____ Address _____

Spouse's Employer _____ Address _____

Whom may we thank for referring you to us _____

Do you have health insurance? Yes _____ No _____

Company _____ CARDHOLDER DOB _____

SOCIAL SECURITY # _____

LIST CHIROPRACTORS YOU HAVE SEEN BEFORE:

1. Name _____ Address _____
   When _____ Diagnosis? _____
   Were x-rays taken? _____ When _____
2. Name _____ Address _____
   When _____ Diagnosis? _____
   Were x-rays taken? _____ When _____

LIST MEDICAL DOCTORS CONSULTED WITHIN PAST YEAR:

1. Name _____ Address _____
   Diagnosis _____
2. Name _____ Address _____
   Diagnosis _____

Present Family Doctor _____ Address _____

Date of last physical examination _____ Doctor _____

WHAT IS YOUR MAJOR COMPLAINT? LIST OTHER PROBLEMS OR COMPLAINTS ACCORDING TO SEVERITY OF PAIN.

1. _____
2. _____
3. _____
4. _____
5. _____

Have you been sleeping well? _____

Have you had this condition before? Yes _____ No _____

How long have you had this condition? _____

BLOOD PRESSURE _____

IS CONDITION THE RESULT OF:

Auto Accident	Yes _____	No _____
Workman's Compensation	Yes _____	No _____
Other Injury	Yes _____	No _____

LIST OPERATIONS AND YEARS:

_____

_____

(OVER)

LIST MEDICATIONS AND/OR DIET SUPPLEMENTS YOU ARE PRESENTLY TAKING:

1. What_____ Frequency_____ Doctor _____
2. What_____ Frequency_____ Doctor _____
3. What_____ Frequency_____ Doctor _____
4. What_____ Frequency_____ Doctor _____
5. What_____ Frequency_____ Doctor _____

WHAT IS YOUR USE OF THE FOLLOWING:

Habits	None	Light	Moderate	Heavy
Smoking	_____	_____	_____	_____
Coffee	_____	_____	_____	_____
Alcohol	_____	_____	_____	_____
Soft Drinks	_____	_____	_____	_____
Salt	_____	_____	_____	_____

CHECK THE FOLLOWING CONDITIONS YOU HAVE HAD BEFORE OR HAVE NOW:

_____Allergy
_____Emphysema
_____Neuritis
_____Arthritis
_____Hi Blood Pressure
_____Pneumonia
_____Constipation
_____Irregular Periods
_____Migraine
_____Stroke
_____ Ulcers
_____Whooping Cough
_____Eczema
_____Mumps
_____Arteriosclerosis
_____Gout
_____Pleurisy
_____Convulsions
_____Menstrual Cramps
_____Sinus
_____Diarrhea
_____Heart Attack
_____Venereal Disease
_____Low Blood Sugar
_____Multiple Sclerosis
_____Anemia
_____Gall Bladder
_____Depression
_____Cancer
_____Malaria
_____Headaches
_____Diabetes
_____Miscarriage
_____Tuberculosis
_____Thyroid Problem
_____Leg Pain
_____ Alcoholism
_____Epilepsy
_____Nervousness
_____Backaches
_____Heart Disease
_____Polio
_____Cold Sores
_____Measles
_____Rheumatic Fever

FAMILY HISTORY:

Please tell us about the health of your parents, siblings and children. Circle or check everything that applies. If someone is deceased, please check or write in the cause.

	Living/Deceased	Heart Disease	Stroke	Cancer	Diabetes	Rheumatoid Arthritis	Multiple Sclerosis	Lung Disease	Bone Disease
Father	L D Cause								
Mother	L D Cause								
Sibling M Child F	L D Cause								
Sibling M Child F	L D Cause								
Sibling M Child F	L D Cause								
Sibling M Child F	L D Cause								
Sibling M Child F	L D Cause								
Sibling M Child F	L D Cause								
Sibling M Child F	L D Cause								

PLEASE NOTE: THIS OFFICE WILL GLADLY PREPARE INSURANCE FORMS AND REPORTS. PLEASE INFORM THE RECEPTIONIST.

VANCE CLINIC OF CHIROPRACTIC

Informed Consent To Receive Chiropractic Care

To the patient: As required by law, please read this entire document prior to signing it. It is important that you understand the information contained in this document. Please ask any questions before you sign if there is anything unclear.

The chiropractic adjustment:

The primary treatment used to treat you at Vance Chiropractic Clinic is spinal manipulative therapy. The doctor of chiropractic will assess your joints for any subluxations and will then put his hands on specific joints in order to remove the subluxation. During the adjustment, there may be an audible "pop" or "click", much like when you "crack" your knuckles. You may feel a sense of movement in that area.

The material risks inherent in chiropractic adjustment:

As with any healthcare procedure, there are certain complications which may arise during chiropractic manipulation and therapy. I understand that in the practice of chiropractic there are extremely minimal risks to treatment, including, but not limited to: strains and sprains, disc injuries, fractures and stroke. Some patients may feel some stiffness and soreness following the first few days of treatment. We will make every reasonable effort during the examination to screen for contraindications to care, however, if you have a condition that would otherwise not come to my attention, it is your responsibility to inform us.

The probability of those risks occurring:

Fractures are very rare occurrences and generally result from some underlying weakness of the bone which is checked for during the taking of your history and during the examination. Stroke has been the subject of tremendous disagreement. The incidences of stroke are exceedingly rare and are estimated to occur between one in one million and one in five million cervical adjustments. The other complications are also generally described as rare.

At Vance Clinic of Chiropractic your best interest is at the core of our treatment.

I have read the above explanation of the chiropractic treatment and related treatment in its entirety. I have discussed any questions with Vance Clinic of Chiropractic and they have answered them to my satisfaction. I wish to rely on the doctor to exercise judgment during the course of the procedure for which the doctor feels is in my best interest. By signing below I state that I have weighed the risks involved in undergoing treatment and have decided that it is in my best interest to undergo the treatment recommended. Having been informed of the risks, I hereby give my consent to that treatment.

(Print Name)
Patients Name: _____

Address: _____

Signature of Patient or Guardian: _____ Date: _____
(Signature)

VANCE CLINIC
1420 SOUTH 14TH STREET
QUINCY, IL 62301
PHONE: (217)-228-1605
FAX: (217) 228-9001

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 office policy requires payment in full for all services rendered at the time of visit, unless other arrangements have been made with the front desk. **If the amount is not paid within 90 days of service, and no financial arrangement has been made, debtor agrees to pay all collection agency fees and legal cost pertaining to collections on this account.**

I hereby authorize payment of benefits directly to the provider of benefits due me for services rendered. I further authorize the physician and/or supplier to release any information required to process insurance claims.

I understand the above information and guarantee this form was completed correctly to the best of my knowledge. I also understand it is my responsibility to inform this office of any changes in my medical status.

Signature of Responsible Person_____

Date_____

If you have any questions feel free to contact our office at any time.

VANCE CLINIC PLLC

RYAN MILLER, D.C.
RYAN BRUENGER, D.C.
TOM VANCE, D.C.

1420 SOUTH 14TH STREET
QUINCY, ILLINOIS 62301
TELEPHONE: (217) 228-9000
FAX: (217) 228-9001

Acknowledgement of our notice of privacy practice

I hereby acknowledge that I have received or have been given the opportunity to receive a copy of Vance Clinic PLLC Notice of Privacy Practices. By signing below I am "only" giving acknowledgment that I have received or have had the opportunity to receive the Notice of our Privacy Practices.

_____ _____

Print Name Date

_____

Signature