

Acct #: _____

Casey Family Chiropractic, PLLC
Dr. Brian T. Casey
68 E. Main St. Washingtonville, NY 10992

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**PLEASE TELL
US ABOUT YOU...**

Today's Date ____ / ____ / ____

Who May We Thank for Referring You to Our Office?

Your Name _____
 Male Female

Birth day ____ / ____ / ____ Age ____

E-mail: _____

@ _____

Home Address _____
Street Apt. #

City State Zip Code

Home Phone #: (____) _____

Mobile Phone# (____) _____

Work Phone #: (____) _____ Ext. ____

Occupation: _____

Employer's Name: _____

Address _____
Street Bldg. # Floor

City State Zip Code

Marital Status:
 Single Married Divorced/Separated Widowed

Spouse and Children's names & ages _____

In case of emergency, whom should we contact?

Name Relation
(____) (____)
Daytime Phone Number Evening Phone Number

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**YOUR CURRENT
HEALTH GOALS...**


Please check the choice(s) that most closely describe you:

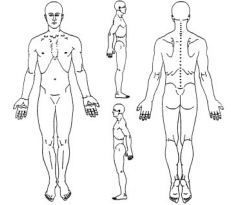
- I am only concerned with the relief of a particular symptom.
- I am concerned about relief of a particular symptom, and preventing it's return.
- I want to perform at my highest capacity.

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**PLEASE TELL US
THE REASON FOR
YOUR VISIT TODAY...**

Please tell us the reason for your visit with the specific area of complaint : _____

Please mark the diagram to the right where you feel this problem(s) 



For how long? _____
(days, weeks, months, years)

What have you tried to do regarding this condition?
(pain meds, PT, massage, etc.)

Pain Scale, please circle (0= No pain, 10= Unbearable pain)
0-1-2-3-4-5-6-7-8-9-10

Have you seen a chiropractor before? Yes No

How long ago? _____ Same condition? Y / N

What medications are you presently taking? _____

Do you have any other health concerns? _____

For office use: 1) ____ . ____ 3) ____ . ____ 5) ____ . ____

2) ____ . ____ 4) ____ . ____ 6) ____ . ____

Other) ____ . ____ . ____ . ____

"PLEASE CONTINUE ON THE BACK" 

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GETTING TO KNOW YOU...

To help us better explain your chiropractic condition and how we may best serve you, please answer the following questions.

- 1 Please list the 3 things in your life that are most important to you
- A. _____
- B. _____
- C. _____

- 2 I remember important things in my life by (**choose one**):

What I see What I hear How I feel

- 3 The primary reason I brush my teeth is to (**choose one**):

- Avoid tooth decay and gum disease
- Make sure I have healthy teeth and gums

- 4 When I make decisions, I generally:

- Gather facts and weigh the evidence
- Make my choice instantly
- Consult my family and friends
- It depends on how I feel about it

- 5 Please share any hobbies and activities that you like to do that have been affected by your present state:

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INSURANCE INFORMATION

Please present your insurance card(s) to the front desk

Primary Insurance Company

Company Name _____ Primary insured _____ DOB ____/____/____ Relation: _____

Secondary Insurance Company

Company Name _____ Primary insured _____ DOB ____/____/____ Relation: _____

I authorize any holder of medical or other information about me to release to my doctor, health insurance carrier or their intermediaries, any information necessary for my medical care or to process this or any related health insurance claim. I hereby authorize payment of benefits to be made directly to Dr. Brian T. Casey, I permit a copy of this authorization to be used in place of the original. I understand that all fees for service rendered are my responsibility regardless of my insurance coverage. This office may elect to accept benefits assigned on a case-by-case basis. All fees not paid by my insurance carrier are to be paid in full by me. Our office policy requires payment in full for all services rendered at the time of the visit, unless other arrangements have been made with our office. I understand that if the account is not paid within thirty (30) days, I will be responsible for any expenses incurred in collecting my account, including but not limited to, referral to a collection agency. I understand it is my responsibility to inform this office of any change in my personal information. (i.e. address, phone number, insurance information, medical or health status.)

“ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSON FILES AN APPLICATION FOR COMMERCIAL INSURANCE OR A STATEMENT OF CLAIM FOR ANY COMMERCIAL OR PERSONAL INSURANCE BENEFITS CONTAINING ANY MATERIALLY FALSE INFORMATION, OR CONCEALS FOR THE PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY FACT MATERIAL THERETO, AND ANY PERSON WHO, IN CONNECTION WITH SUCH APPLICATION OR CLAIM, KNOWINGLY MAKES OR KNOWINGLY ASSISTS, ABETS, SOLICITS OR CONSPIRES WITH ANOTHER TO MAKE A FALSE REPORT OF THE THEFT, DESTRUCTION, DAMAGE OR CONVERSION OF ANY MOTOR VEHICLE TO A LAW ENFORCEMENT AGENCY, THE DEPARTMENT OF MOTOR VEHICLES OR AN INSURANCE COMPANY, COMMITS A FRAUDULENT INSURANCE ACT, WHICH IS A CRIME AND SHALL ALSO BE SUBJECT TO A CIVIL PENALTY NOT TO EXCEED FIVE THOUSAND DOLLARS AND THE VALUE OF THE SUBJECT MOTOR VEHICLE OR STATED CLAIM FOR EACH VIOLATION.”

(print name)

(signature)

____/____/____
(date)

IF YOU HAVE ANY QUESTIONS OR CONCERNS, PLEASE SPEAK TO US BEFORE SIGNING THIS DOCUMENT.

(doctor's name)

(signature)

____/____/____
(date)