Private Patient Cases
CONFIDENTIAL PATIENT INFORMATION – Please Print

Date_____
Cell #:_____

Patient's Name_____ Home Phone #:_____

Address:_____ Street:_____ City _____ State _____ Zip Code_____

Age _____ Date of Birth _____ Social Security #_____ Status M S D W

Occupation _____ No of Children _____

Employer _____ Address _____
Referred by_____

CONFIDENTIAL HISTORY INFORMATION – Please Print

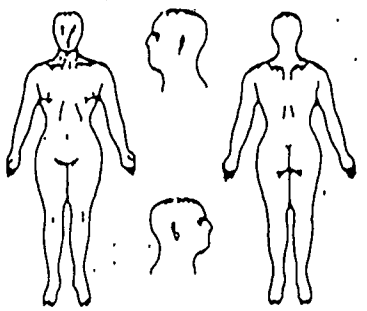
IS THIS CONDITION THE RESULT OF AN ACCIDENT? YES NO (Circle One)
Date of Last Physical Examination _____ By Whom_____
Have you been treated for any health condition by a physician in the last year? YES NO (Circle One)
Please Describe _____
Have you ever had chiropractic care before? YES NO (Circle One) Doctors Name _____
Have you ever suffered from any of the following? Please indicate by checking.

___DIZZINESS	___HIGH BLOOD PRESSURE	___ASTHMA	___CANCER	___BACHACHES
___DIABETES	___RHEUMATIC FEVER	___NEURITIS	___HEADACHE	___TUBERCLOSIS
___ALLERGIES	___DIGESTIVE DISORDES	___ARTHRITIS	___ANXIETY	___HEARTTROUBLE

CONFIDENTIAL CURRENT INFORMATION – Please Print

Purpose if this appointment _____
What type of physician have you seen for this condition _____ Chiropractor ___Medical _____None

What, if any, medications or drugs are you taking? _____
Please mark your areas of pain on the figure below.



List the conditions that you are most interested in getting corrected. List in order of importance.
1._____
2._____
3._____
4._____

What functions are you unable to perform or induce Pain upon performance? (IE sitting, bending, working)
1._____
2._____
3._____
4._____

WOMEN: Are you pregnant at this time? YES NO (Circle One)

CONFIDENTIAL INSURANCE INFORMATION – Please print

Are you insured? YES NO (Circle One) If you please list below.
BASIC MEDICAL CARRIER_____ POLICY # _____
Address_____
MAJOR MEDICAL CARRIER _____ POLICY # _____
Address_____
SPOUSE'S BASIC CARRIER MEDICAL CARRIER_____ POLICY # _____
Address_____
MAJOR MEDICAL CARRIER _____ POLICY # _____

BILLS FOR PROFFESIONAL SERVICES RENDERED ARE DUE AND PAYABLE AT THE TIME OF YOUR APPOINTMENT

PAYMENT ACKNOWLEDGMENT – Please Sign

I hereby acknowledge and understand that I am responsible for my bills for professional services rendered:

_____ _____
Signature Date

INSURANCE AUTHORIZATION AND AGREEMENT

I understand and agree that health & accident policies are an arrangement between an insurance carrier and me. Furthermore, I understand that Dr. Raymond A. Semente will prepare any forms and reports and that he may release any information concerning my case in preparation to be paid directly. 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 for any reason the insurance company refuses to pay any part of my bill that I am directly responsible for payment. I further understand that if I suspend of terminate my care any fees for professional services rendered to me or my dependant will immediately become due and payable.

_____ _____
Signature Date

_____ _____
Insured Signature Date

I am approved by the Professional Chiropractic Society of America