Patient # _____

Personal History

Name: _____ Gender (circle one): M F

Address: _____ City: _____ State: ____ Zip: _____

Home Phone: _____ Work: _____ Cell: _____

Date of Birth: _____ Age: _____ Height: _____ Weight: _____

Marital Status: _____ SSN: _____

Employer Name: _____ Occupation: _____

Email Address: _____

Family Physician: _____

Do You Smoke: [ ] Never Have [ ] Quit [ ] Yes

Alcohol Consumption: [ ] Never [ ] Social [ ] Light [ ] Moderate [ ] Heavy

Current Health Condition

Injury/Complaint: _____

Due to: [ ] Auto Accident [ ] Slip and Fall [ ] Other:_____

Date of Occurrence: _____ Was it at work?_____

Date symptoms Appeared: _____ Have you had these Symptoms before? _____

If yes, when? _____

Are your symptoms: [ ] Improving [ ] Getting Worse [ ] About the same [ ] Intermittent

Aggravated by: [ ] Standing [ ] Sitting [ ] Walking [ ] Bending [ ] Lifting [ ] Lying down

[ ] Twisting [ ] Coughing

Please identify pain scale (0 being no pain and 10 being Unbearable):

0 1 2 3 4 5 6 7 8 9 10

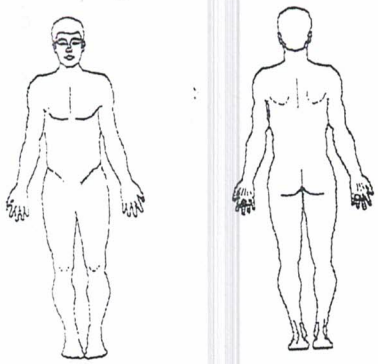
How often are symptoms present?

[ ](intermittent) 0-25% [ ](occasional) 26-50% [ ](frequent) 51-75% [ ] (constant) 76-100%

Current Medications: _____

Females only: Last menstrual cycle: _____ Are you pregnant now? _____

Please identify on the diagram your area of pain or discomfort as completely as possible.



Past Medical History

Major Surgeries/year: [ ] Appendix_____ [ ]Tonsils_____ [ ]Gall Bladder_____

[ ] Heart_____ [ ] Neck_____ [ ] Back_____ [ ] Female_____

[ ] Other:_____

[ ] Fractures (type/year)_____

[ ] Serious Illness 9type/year) _____

Emergency Contact: _____

Relationship: _____ Phone number: _____

I hereby direct payment to be made directly to Gibson Chiropractic & Wellness and assign Gibson Chiropractic & Wellness a lien in the amount of my bill for health care services against any proceeds of any insurance policy, healthcare plan, and against any claim which I may have against any other party whose negligence may have caused my injuries, or who may legally be responsible for my injuries, illness, or healthcare cost. I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that Gibson Chiropractic & Wellness will prepay any necessary reports and forms to assist me in making collection from the insurance and that any amount authorized to be paid directly to Gibson Chiropractic & Wellness will be credited to my account on receipt. However, I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. Further, I understand that if my account becomes 60 days overdue with no acceptable payment, my account will be turned over to a collection agency/attorney, and will be responsible for all fees involved in addition to my original balance. I also understand that if I suspend or terminate my care at this office any outstanding charges or professional services rendered me will be immediately due and payable. I further certify that the above information is true and correct to the best of my knowledge and will notify within 2 weeks of any changes in the information contained herein. I understand the insurance verification done by this office and discussed with me as provided by my insurance representative is not a promise or guarantee of payment by my insurance carrier and I will not hold this clinic responsible for discrepancies in the benefit quoted and the benefit actually paid.

Patient/Guardian Signature: _____ Date:_____

Gibson Chiropractic & Wellness

1922 South Union
Opelousas, La.
(337) 678-3300

Patient's Name: _____ Acct. #_____

Consent for Chiropractic Treatment

_____ I hereby authorize and direct Gibson Chiropractic & Wellness to provide chiropractic treatment including examination /diagnostics, spinal manipulation/adjustments, various of physical therapy, x-rays, and any additional procedures or services that may be deemed necessary or reasonable.

_____ I hereby authorize and direct Dr. Gibson of Gibson Chiropractic & Wellness, to provide chiropractic treatment as she deems necessary to my _____.

This authorization for and consent to chiropractic treatment is and shall remain valid until revoked.

_____ _____

Signature of Patient Date

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Pregnancy Release for X-rays

I hereby state to the best of my knowledge that I am not pregnant and give full permission to Gibson Chiropractic & Wellness, and their state licensed x-ray technicians, to x-ray me.

_____ _____

Signature of Patient Date

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Pacemaker

_____ I do have a pacemaker. _____ I do not have a pacemaker.

_____ _____

Signature of Patient Date

C. Michelle Gibson, D.C.
Gibson Chiropractic & Wellness
1522 South Union Street
Opelousas, La. 70570
(337) 678-3300

BILLING AND PAYMENT

In connection with your Chiropractic Treatment, payment may be made by any of the following methods. Please indicate your method of payment below:

_____(initial) Self-Pay: If you have no available insurance coverage, you will be billed for services provided.

_____ (initial) Health Insurance: We will bill your health insurance provider if, at the time of service, we are a contracted provider with that insurance company. However, you must remit all payments due as a result of any deductible, co-insurance and /or co-payments per the insurance plan. These payments as well as payments for services not covered under the plan are due at the time each service is rendered.

_____(initial) Third Party Fault: In the event that a third party is at fault for your injury and you wish for us to bill that third party or your automobile medical payments carrier instead of you health insurer, then we will attempt to collect front the third party at the full cost of our services. However, if, in the event that the third party recovery is unsuccessful, you will be responsible for the full amount of the outstanding medical bill.

Patient's Printed Name:_____

Patient's signature:_____

Patient's Representative (if a minor):_____

Relationship to Patient: _____Date: _____

Name of Attorney (if represented): _____

Attorney Address: _____

Attorney Phone: _____