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Back Specialists
Sioux Falls, SD

PATIENT INFORMATION

Payment is expected at the time of visit unless prior arrangements have been made.

Patient Information:

First Name:________________________MI:_____Last Name:__________________________________
Street: ____Apt :__________________
City: ____State:________Zip:________________
Social Security #:_______-_____-_______ Marital Status: ___S___M___W___D Spouse:______________
Language:___English___Spanish___Indian___Japanese___Chinese___Korean___French___German
___Russian___Other_____________________
Race:___White___American Indian or Alaska Native___Asian___Native Hawaiian/Other Pacific Islander
___Black or African American___Decline to answer___Other
Ethnicity:___Hispanic or Latino___Not Hispanic or Latino___Decline to answer
DOB:______________Home Phone:_____-_____-__________Work Phone:_____-______-____________
Cell Phone:______-______-_________ Cell Carrier:_______________________________
Please check your contact preference:___Hm___Wk___Cell___Email___Post Mail
Email Home:_____________________________ Email Work:______________________________
Emergency Contact:____________________________Phone Number:_____-______-____________
Who may we thank for referring you to our office?_____________________________________
Occupation:______________________________Employer:________________________________
Employer Address:____

We will make a copy of your insurance card/s. However, please complete the following information.

Insurance Information:

Are you the policy holder___Y___N If no, who is policy holder___Spouse___Parent___Employer___Other
Policy Holder First Name:_______________________MI___Last Name___________________________
Policy Holder's DOB:__________________________Policy Holder's SS#_____-___-_________
Policy Holder's Employer:______________________________________
Do you have secondary insurance coverage___Y___N If yes, please complete the following:
Policy Holder First Name:_______________________MI___Last Name___________________________
Policy Holder's DOB:__________________________Policy Holder's SS#_____-___-_________
Policy Holder's Employer:______________________________________

Patient History:

Are you seeing anyone else for other problems or health conditions?___Y___N
Please list the problem/s, date problem/s. began, and provider/s treating you for the condition/s:
____
Can we send updates to your physician of choice? ___Y___N Name/Location of physician:____________
____
Past health history—Have you been diagnosed with diabetes?___Y___N___Type I___Type II
Have you been treated for hypertension? ___Y___N
Do you smoke?___Never___Former Smoker___Current/Everyday Smoker___Current Smoker
Medications—What medications are you currently taking? Include vitamins, herbs, minerals….
List the date started, brand/generic name, strength, dosage, frequency, duration, quantity, prescribed by:
____
____
____
Do you have allergies?___Y___N___Food___Environmental___Medication
Type/list/reaction:____

Assignment & Release:

Insurance Information

I understand and agree that health and accident insurance policies are an agreement between an insurance carrier and myself. Furthermore, I understand that this office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to this doctors office will be credited to my account upon receipt. 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 or outstanding balances for service I have received will be immediately due and payable.

Patient's/Parent's/Guardian's Signature:_________________________________Date:__________

Consent of Professional Services and Release of Information

I hereby authorize and release the doctor and whomever he/she may designate as his/her assistants, to administer treatment, physical examination, x-ray studies, laboratory procedures, chiropractic care of any clinic services that he/she deems necessary in may case; I furthermore authorize him/her to disclose all or any part of my patient record to any person or corporation which is or may be liable under a contract to this office or to the patient or to a family member or employer of the patient for all or part of the clinic's charge, including and not limited to hospital or medical service companies, insurance companies, worker's compensation carriers, welfare funds, or the patient's employer.

Patient's/Parent's/Guardian's Signature:_________________________________Date:__________