Family Health History/Record

Name of Relative	**Approximate Age Of Relative**	**Health History** Please Include Any Conditions Including: *Neck/Back/Headache or Other Musculoskeletal Pain, Ear Infections, Cardiovascular Conditions, Cancer, Diabetes, Autoimmune Disorders, etc.*
Husband/Wife:		
Children:		
Mother:		
Father:		
Sisters:		
Brothers:		
Grandparents :		

Is your current condition related to an accident? ˜ work related ˜ auto related ˜ other _____ ___.

Do you have health insurance? ˜ Name of company _____ ˜ Medicare ˜ MA/MN Care ˜ None

All first visit charges are payable when services are rendered. Method of payment? ˜ Cash ˜ Check ˜ Visa/MC

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Further, I understand that the Doctor's 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 the Doctor's Office 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. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered me will be immediately due and payable. I also understand that the Doctor's Office does not bill individual patients, but that a billing charge of $5.00 will be applied to any balances 90 days or older and a statement will be sent at that time. Failure to contact the Doctor's Office to finalize credit arrangements on a balance of 90 days or older, will result in the referral of your account to our professional collection service.

I hereby authorize the Doctor to treat my condition as he deems appropriate through the use of manipulation throughout my spine. It is understood and agreed the amount paid the doctor for X-rays, is for examination only and the X-ray negatives will remain the property of this office, on file where they may be seen by the patient at any time, while still a patient at this clinic. The Doctor will not be held for any pre-existing medically diagnosed conditions, nor for any medical diagnosis.

Patient's Signature: X_____ SS #: _____ Date: _____