THE CHIROPRACTIC CENTER OF LAS VEGAS

Welcome To Our Office

Please fill out completely

Patient Information

Date:_____

Name:_____

Address:_____

City:_____ State:_____ Zip:_____

Sex:_____ Age:_____ Birthdate:_____

Marital Status: □Single □Married □Widowed □Divorced

Social Security Number:_____

Occupation:_____

Employer:_____

Employer Address:_____

Employer Phone:_____

Spouse's Name: _____

Spouse's Birthdate: _____

Spouse's Occupation:_____

Spouse's Employer:_____

If applicable: Have you ever been to a chiropractor before:

Y/N Name of chiropractor:_____

Date last seen: _____

Insurance Information

Name of Insured:_____

Relationship to Patient:_____

Insurance Co.:_____

Group #_____

ID# _____

Is Patient Covered by Additional Insurance? □Yes □No

Subscribers Name:_____

SS#_____ Birthdate:_____

Relationship to Patient_____

Insurance Co. _____

ID #_____

Assignment, Release and Certification Signature

I, the undersigned certify that I or my dependent have insurance coverage with the above insurance company and assign directly to KEVIN L. KALDY, DC, PC or Dr. Kaldy all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by my insurance company. I hereby authorize KEVIN L. KALDY, DC, PC . or Dr. Kaldy and staff to release all information necessary to secure the payment of benefits. I authorize the use of my signature below on all insurance forms.

_____

Responsible Party Signature (If necessary):

_____ _____

Relationship Date

Contact Information

Home_____ Mobile_____

Work_____ Ext._____

Best Time To Reach You:_____

Email Address:_____

In Case Of An Emergency Contact:

Name:_____

Relationship:_____

Home Telephone:_____

Work Telephone:_____Extension:_____

Injury Information

Is condition due to an accident? □Yes □No

Type of accident: □Auto □Work □Home □Other

Who have you made a report of your accident?

□Auto Insurance □Employer □Worker Comp. □Other

Attorney Name (if Applicable):_____

_____

Chief Complaint

Reason for Visit:_____

What date did your complaint first start? _____

Rate your pain on a scale of 1(least) to 10 (worst):_____Is it getting worse? □Yes □No

Frequency of your complaint: □Constant □Off and On

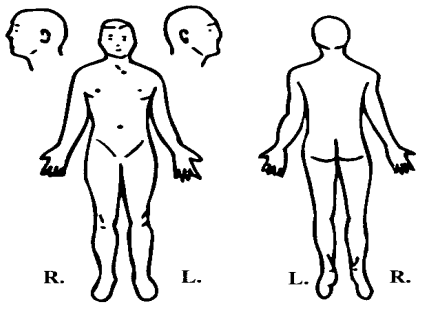
Nature of complaint: □Sharp □Dull □Throbbing □Numbness
□Tingling □Aching □Shooting □Burning

Does your complaint interfere with: □Work □Play □Daily Routine □Sleep

Activities or movements difficult to perform: □Sitting □Standing □Walking
□Bending □Lying Down

Additional Comments:_____

Mark an (X) below where you are having pain, numbness, or tingling



Patient Name:_____ Date:_____

Health History

How long can you sit without pain:_____minutes Do you have pain while lying on your back? Y/N

How long can you stand without pain:_____minutes Do you experience pain going to the bathroom? Y/N

Can you get dressed without pain: Y/N Are you experiencing sharp pain with deep breathing? Y/N

Family Doctors Name:_____

Other Doctors Names: _____

List all drug allergies that you have:_____

List all surgeries you have had:_____

List any fractures you have had:_____

List all prescription or over the counter medications you are taking:_____

_____

List all health problems or other diseases that you currently have: _____

_____

_____

Height _____ Weight_____ Dominant Hand: ____Right ____Left

Do you smoke? □Yes □No How many packs per day? ____

Do you drink alcohol? □Yes □No # of drinks per day_____ □ Socially

Do you exercise regularly? □Yes □No

Type of work: □ Clerical □ Light Labor □ Moderate Labor □ Heavy Labor

Recent Radiology Dates & Location: □X-ray _____□MRI_____

□CT Scan_____ □Ultrasound_____

For women only

Is there any possibility that you may be pregnant? □Yes □No

Signatures

I certify that the above information is correct to the best of my knowledge. I will not hold my doctor or any members of their staff responsible for any errors or omissions that I my have made in the completion of this form.

Signature:_____ Date_____