

**Confidential
Patient
Information**

Abundant Health Family Chiropractic, P.C.
Kimberly A. Maxwell

642 Cottonwood Rd, Ste 1
Bozeman, MT 59718
406-585-7000

116 Ousel Falls, Rd, P.O. Box 160502
Big Sky, MT 59716
406-993-2233

Date: _____ Last Four Digits of Social Security #: _____

Name: _____ Home Phone: () _____

Address: _____ State: _____ Zip Code: _____

Age: _____ Birth Date: _____ Cell Phone: _____

Gender: Female Male

Occupation: _____ Work Phone: () _____

Employer: _____ Address: _____

Spouse/Nearest Relative: _____

Children: _____ E-mail: _____

Who referred you to my office?: _____

Have you ever been to a chiropractor before? Yes No
If yes, when was last visit? _____

Do you have any symptoms? If so, what are they and how have they affected your life?

If this is work related, have you reported it to your employer? Yes No

Is this related to an auto accident? Yes No
Date of Accident: _____

Are you currently under any Medical care?

Have you been treated for any health conditions by a Medical Doctor in the last year? Yes No
If yes, please explain: _____

FEMALES: Are you pregnant? Yes No Not Sure

Revised: 10/1/2008

If the Doctor determines that services are necessary, all charges are payable when rendered.

What form of payment will you use? Cash Check Credit Card

Are you Insured? Yes No

If Yes, please hand Receptionist to copy

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that Active Care Family Chiropractic, P.C. will prepare any necessary reports and forms to assist me in making collection from the insurance company. 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 hereby authorize the doctor at AbundantHealthFamily-Chiropractic, P.C. (AHFC) and whomever they may designate as their assistants to administer any care, as they deem necessary. I certify that the above information is true and correct.

In the event that I make a special arrangement with AHFC, P.C. to bill insurance for me I authorize the release of any medical or other information necessary to process the claim. I also request payment of government benefits either to my self or to the party who accepts assignment.

Print Name _____ Signature _____ Date: _____
(This signature is effective for 24 months, unless sooner revoked in writing.)

If necessary, signature of guardian _____
(This signature is effective for 24 months, unless sooner revoked in writing.)

Terms of Acceptance

When an individual seeks chiropractic health care and I accept this individual for such care, it is essential for both to be working towards the same objective.

Chiropractic has only one goal. The goal is to eliminate Subluxations within the spinal column, which interferes with the expression of the body's innate wisdom. It is important that you as the patient understand both the objective and the method that will be used to attain our goal. This will prevent any confusion or disappointment.

Adjustment: An adjustment is the specific application of forces to facilitate the body's correction of vertebral Subluxation. My chiropractic method of correction is specific adjustments of the spine and extremities.

Health: A state of optimal physical, mental, and social well being, not merely the absence of disease or infirmity.

Vertebral Subluxation: A misalignment of one or more of the 24 vertebrae in the spinal column which causes alteration of nerve function and interference to the transmission of mental impulses, resulting in a lessening of the body's innate ability to express its maximum health potential.

Ancillary treatment: In addition to spinal adjustments I may adjust subluxations in other joints of the body. When necessary I may also recommend specific exercises and /or therapies such as ice, heat, electrical stimulation or ultrasound.

I do not offer to diagnose or treat any disease or condition other than Subluxation. However, if during the course of chiropractic examination we encounter non-chiropractic or unusual findings, I will advise you. If you desire advice, diagnosis, treatment for those findings, I will recommend that you seek the services of a health care provider who specializes in the area.

Regardless of what the disease is called, I do not offer to treat it. Nor do I offer advice regarding treatment prescribed by others. **MY ONLY PRACTICE OBJECTIVE** is to eliminate major interference to the expression of the body's innate wisdom. My method is specific adjusting to correct vertebral and joint Subluxations.

I, _____ have read and fully understand the above statements.

Signature _____

If necessary, signature of guardian _____