

DOUGLAS O. PITT, B.S., D.C.

Auburn Chiropractic Health Clinic, Inc.

Glendean Shopping Center

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Auburn, Alabama 36830

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Patient Information

Welcome to our office! Please complete all questions.

Who may we thank for referring you? _____

Name: _____	Date: _____		
Address: _____	City: _____	State: _____	Zip: _____
Home Phone: _____	Work Phone: _____	Other: _____	
Birth date: _____	Age: _____	Height: _____ ft. _____ in.	Weight: _____ lbs.
SSN: _____ - _____ - _____	Sex: M or F	Marital Status: Married Single Divorced Widowed	
Place of Employment _____	Employer Phone Number _____		
Method of payment for first visit: Cash _____	Check _____	Credit Card _____	
Financially responsible party – Name: _____	Relationship: _____		
Address: _____			
Phone Number: _____			
Date of Birth on Insurance Card and/or birth date of Guarantor: _____			

List your chief complaints in order of severity:
1. _____ For how long? _____
2. _____ For how long? _____
Where is the pain? _____ Does it spread? Yes _____ No _____ If yes, where? _____
Do you have numbness? Yes _____ No _____ If yes, where? _____
Is there pain when you cough or sneeze? Yes _____ No _____ If yes, where? _____
Is there pain when you go from sitting to standing? Yes _____ No _____ If yes, where? _____

Do you have headaches? Yes _____ No _____	If yes, circle all that apply:
TENSION THROB SINUS MIGRAINE OTHER: _____	
Indicate below any functions that aggravate or are aggravated by your condition (circle all that apply):	
Walking Step Climbing Driving Working Recreation Bowel Movements Digestion	
Vision Breathing Sinuses Hearing Smelling Sleeping	

“Changing the way you think about health...”

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Name of Insurance Company: _____	
Address: _____	City: _____ State: _____ Zip: _____
Phone Number: _____	Group Policy Name: _____
Group ID# _____	Personal/Member ID# _____
Name of Insured: _____ Is patient a dependent under this policy? Yes__ No __	

I/we hereby authorize and direct my insurance benefits to be paid directly to Auburn Chiropractic Health Clinic for an unexpired period of time. I understand that I am responsible for any portion of my bill that my insurance company does not pay or for non-covered services. Failure to make payments according to office policy is basis for legal action, and I agree to pay all costs of collection including reasonable attorney fees and court costs. I waive my right to claim exemption under the Constitution and Law of the State of Alabama or any other state.

I agree to pay for services rendered to the above-mentioned patient as the charges are incurred. I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself, and that I am personally responsible for payment of any and all services covered or non-covered. I also understand that if I suspend or terminate my, or my child's, care and treatment, any fees for professional services rendered to me will be immediately due and payable.

I hereby give permission to Dr. Pitt or _____ (and whomever they may designate as their assistants) to administer treatment, and to perform such general procedures as they may deem necessary in the diagnosis and/or treatment of my, or my child's, condition. I also certify that no guarantee has been made as to the results that may be obtained.

I hereby verify that I have read and reviewed the above information and represent the same is true, correct, and complete. I understand that Dr. Pitt or _____ will be relying on the above information in their treatment of me. Should Auburn Chiropractic Health Clinic file insurance on my behalf, I hereby give permission to Auburn Chiropractic Health Clinic to release any information requested by my insurance company acquired in the course of my examination and/or treatment.

<i>This information is true and accurate to the best of my knowledge.</i>	
Patient's or Guardian's Signature _____	Date _____