Welcome to Kirchman Chiropractic, LLC

637 Main Street, P.O. Box 236 – Luxemburg, WI 54217 – Phone: 920-845-5654 – Fax: 920-845-5640

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Last First Mi

Home Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Street City WI Zip

Telephone: (\_\_\_\_\_\_)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ SSN #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Birthdate: \_\_\_\_/\_\_\_\_/\_\_\_\_ Age: \_\_\_\_\_\_\_\_\_

Sex: □ Male □ Female Status: □ -Married □ -Single □ -Widowed □ -Divorced Email Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Occupation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Employer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Wk#: (\_\_\_\_\_\_)\_\_\_\_\_\_\_\_\_\_ Number of Children: \_\_\_\_\_\_\_\_

Spouse Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Spouse’s Occupation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Spouse’s Employer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Person responsible for this account/Insured: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Insured’s Birthdate: \_\_\_/\_\_\_/\_\_\_ Insured’s SSN: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Whom can we thank for referring you to our office (name):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Reason for today’s visit:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date problem began:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

EHR-Requirements

Race/Ethnicity: \_\_\_\_\_White \_\_\_\_\_Black/African American \_\_\_\_\_Hispanic/Latino/Spanish origin Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Language: \_\_\_\_\_English \_\_\_\_\_Spanish \_\_\_\_\_Chinese \_\_\_\_\_Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have high Blood Pressure? \_\_\_\_\_Yes \_\_\_\_\_No Do you have diabetes? \_\_\_\_\_Yes \_\_\_\_\_No

Do you take any medications? (Circle one) Yes No

If yes, please give current list (Include dosage & frequency)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Do you have any medication allergies? (Circle one) Yes No

 If yes, please list medication, reaction, onset date, and any additional comments\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_­­­\_\_\_\_\_\_\_\_\_\_\_

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Smoking Status/Tobacco Usage (Circle One) Everyday / Occasional / Never / Start Date:\_\_\_\_\_\_\_\_\_\_\_\_ / Quit Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Financial Disclosure

I, the undersigned acknowledge that I have been advised that certain items including, supports, ice packs, supplements, heel lifts, lumbar or cervical pillows may not be covered under the terms of my health plan. I agree to be personally responsible for these items.

I understand and agree that health and accident insurance companies are an agreement between my insurance carrier and my-self. Furthermore, I understand that this chiropractic office will prepare any necessary reports and forms to assist me in making collections from the insurance company. I also understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. I also hereby give permission to the doctor to release any information requested by my insurance company acquired in the course of examination and treatment.

Authorization

I affirm that the information I have given is correct to the best of my knowledge, and that it is my responsibility to inform this office of any changes in my medical status

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 Signature Date

FOR OFFICE USE ONLY

Height:---------------- Weight:--------------- Blood Pressure:----------------/---------------- Pulse:------------