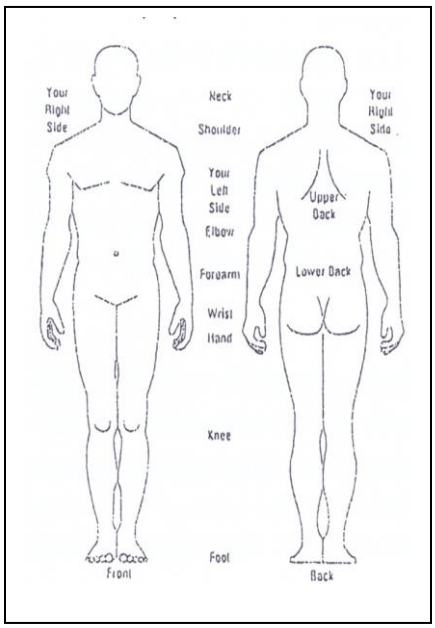
CENTERPOINTE CHIROPRACTIC & PHYSICAL THERAPY
4085 N. JEFFERSON ST., MEDINA, OH 44256

PATIENT HISTORY

Date_____
Name_____Age_____Date of Birth_____
Address_____City_____State_____Zip_____
Phone(h)_____(c)_____ E-mail _____
Married____Single____Divorced____Widowed____ Name of spouse_____
Nearest relatives name and phone_____



How will payments be made: Health Insurance____Self-pay____Auto_____Workers comp____

Mark & describe your major symptoms
_____
_____
_____

Describe mechanism of injury/ how condition developed
_____
_____
Date of Injury/Onset of Symptoms_____
Have you had X-rays taken? Y or N Date_____
Have you had other tests performed? Y or N_____
_____
_____

Name of primary Care Physician_____Phone_____
Address_____City_____State_____

Health History

Current Medications_____
Known Drug Allergies_____
Describe history of surgeries, cancer, serious illnesses, or pre-existing conditions _____
_____
_____
Describe family history of cancer, diabetes, stroke, heart conditions, other _____
_____

Circle if you have or had history of: Alcohol Addiction, Diabetes, High blood pressure, Stroke, Seizure, Drug Addiction, Birth Control Pills, Bowel Dysfunction, Bladder Dysfunction Unexplained Cough, Unexplained Weight Gain. Smoking Y or N Smoking packs per day____
Are you pregnant? Y or N Number of deliveries_____ None of Above

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CONSET OF TREATMENT OF MINOR CHILD

I hereby authorize B. Lou Rossi, DC and Kyle Milligan, PT and whomever they may designate as this assistant to administer Chiropractic/Physical Therapy care as they deem necessary to my son/daughter. Parent /Guardian Signature: _____

ASSIGMENT/INSTRUCTRIONS FOR DIRECT PAYMENT TO DOCTOR

I hereby instruct my insurance company to pay directly to: CENTERPOINTE CHIROPRACTIC AND PHYSICAL THERAPY, 4085 NORTH JEFFERSON ST., MEDINA, OH 44256. Or if my current policy prohibits direct payment to the Doctor, I hereby instruct and direct you to make out the check and mail to the above address the professional or medical expense benefits allowable, and otherwise payable to me under the current policy as payment toward the total charges for professional services rendered. This is a direct assignment of my rights and benefits under the policy.

This payment will not exceed my indebtness to the above-named assignee and I have agreed to pay, in a current manner, an insurance payment. A photocopy of this assignment shall be considered as valid as the original. I also authorize the release of any information pertinent to my case to any insurance company, adjuster or attorney involved in the case. If the insurance company in uncooperative, I authorize CENTERPOINTE CHIROPRACTIC AND PHYSICAL THERAPY to submit a complaint to the insurance commissioner.

HEALTH INSURANCE CLAIM FORM 1500

I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or the party who accepts assignment below.

I authorize payment of medical benefits to the undersigned physician or suppliers for services.

I acknowledge that the above information is true and that I have read and agree to all the above.

_____ _____
Printed Name Date

_____
Signed Name