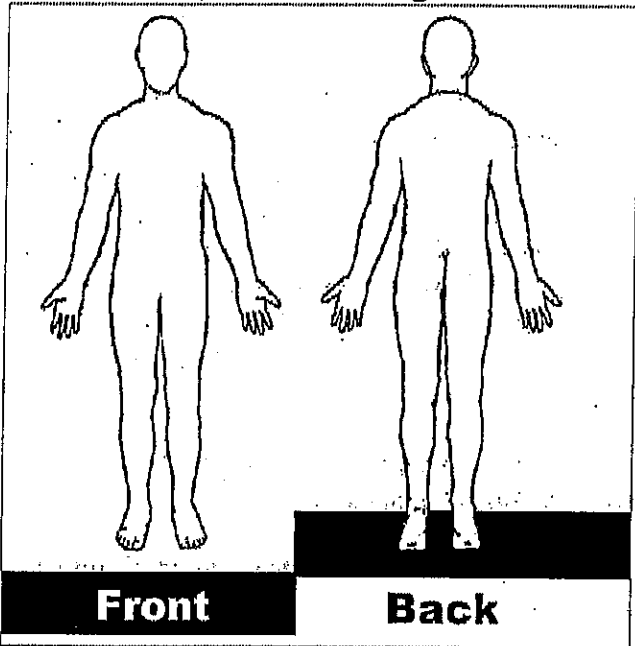


Back N' Balance

New Patient Information

Name _____ Female Male Date _____
 What do you prefer to be called _____ Age _____ Date of Birth _____
 Height _____ Weight _____
 Address _____ City _____ State _____ Zip _____
 Home Phone _____ Cell Phone _____
 Email Address _____ Newsletter sent via email? Yes No
 Preferred Method of Contact _____
 Employer _____ Occupation _____ Work Phone _____
 Emergency Contact _____ Relation _____ Phone _____
 How did you hear about our office? _____
 When did your condition begin? _____
 Other Doctors seen for this condition? _____
 Have you had the same or similar symptoms before? Yes No Date of prior condition _____

Mark Areas of Pain on Figures Below



List chief symptoms in order of severity:

- (1) _____
 (2) _____
 (3) _____

Have you had chiropractic care before? Yes No

Family Physician _____

May we forward our findings to your doctor? Yes No

Current Medications _____

Allergies (Medicine, Food, Environment) _____

Previous Surgeries _____

Do you have a PERSONAL history of: Cancer Diabetes Heart Disease Stroke High Blood Pressure

Other serious illnesses _____

Check all symptoms that apply to you:

- | | | |
|--|--|--|
| <input type="checkbox"/> Headache | <input type="checkbox"/> Shortness of Breath | <input type="checkbox"/> Fatigue |
| <input type="checkbox"/> Neck Pain/Stiffness | <input type="checkbox"/> Chest Pain | <input type="checkbox"/> Night Sweats |
| <input type="checkbox"/> Back Pain/Stiffness | <input type="checkbox"/> Knee Pain | <input type="checkbox"/> Blood in Urine |
| <input type="checkbox"/> Shoulder Pain | <input type="checkbox"/> Hip Pain | <input type="checkbox"/> Pain unrelieved by rest |
| <input type="checkbox"/> Tingling/Numbness in arms/hands | <input type="checkbox"/> Fever | <input type="checkbox"/> Fibromyalgia |
| <input type="checkbox"/> Tingling/Numbness in legs/toes | <input type="checkbox"/> Night Pain | <input type="checkbox"/> Skin Conditions _____ |
| <input type="checkbox"/> Loss of balance/dizziness | <input type="checkbox"/> Unexplained weight loss | <input type="checkbox"/> Other _____ |

Health Insurance

Policyholder Name _____ Date of Birth _____

Workers Compensation

Is your condition due to an Employment-Related Injury Yes No Have you reported it? Yes No

Date of Accident _____

Supervisor _____ Supervisor # _____

Auto Accident

Is your condition due to an Automobile Accident Yes No Date of Accident _____

Auto Accident Insurance name _____ Claim # _____

Adjuster Name _____ Phone # _____

Attorney Name _____ Phone # _____

INSURANCE INFORMATION, CONSENT OF PROFESSIONAL SERVICES, AND RELEASE OF INFORMATION

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that this office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to this office will be credited to my account on receipt. However, I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. I also understand if I suspend or terminate my care and treatment, any fees for professional services rendered to me will be immediately due and payable.

I hereby authorize Ross Batiste, DC, Patricia Snair, DC and their affiliated providers to administer treatment, physical examination, x-ray studies, laboratory procedures, chiropractic care, acupuncture, physical therapy, or any clinic services that they deem necessary in my case; I do hereby give my consent for the performance of conservative non-surgical treatment, including, but not limited to manipulation, physical therapy modalities, soft tissue massage, and therapeutic exercises. I am aware there are possible risks and complications associated with these procedures, including medication and/or surgery. I further authorize them to disclose all or any part of my (patient's) record to any person or corporation which is or may be liable under a contract to the clinic or to the patient or a family member or employer of the patient for all or part of the clinic's charge, including, and not limited to hospital or medical services companies, insurance companies, workers compensation carriers, welfare funds, or the patient's employer.

I understand that if an insurance company initially pays for my treatment and later requests reimbursement from Back N' Balance, Inc. for any reason, I will be responsible for payment of my entire outstanding balance.

We invite you to discuss any questions you might have with us. The best health services are based on a friendly mutually understood relationship.

Patient's or Guardian's Signature _____ Date _____

CONSENT TO TREAT A MINOR

I (we) being the parent, guardian, or custodian of the minor being _____, age _____, do hereby authorize, request, and direct Back N' Balance, Inc., its doctors and staff to perform examinations, diagnostic x-rays, laboratory tests, and any treatment that in their judgement, is deemed advisable or required.

It is the understanding of the undersigned that the physicians and their staff will have full authority from me as legal parent/guardian to continue with examinations, diagnostic tests, and treatments as will be needed while said minor shown above is under care in this office until legal age is attained.

As legal parent/guardian, I realize full responsibility for all charges and payments due.

Parent/Guardian or Custodian Signature _____ Date Signed _____

Witness _____