Valley Chiropractic: A
Creating Wellness Center
3910 East Pages Lane
Louisville, KY 40272

Personal Information

Name ____________________________________ Date of Birth __________________ Age ______
Address _________________________________ City __________________ St _____ Zip _________
Home Phone ______________________ Cell ______________________ Work ___________________
Email Address ____
(Preferred method of contact: phone ___ text ____ email ____ mail ____)
Social Security Number ___________________________ Birth Sex: Male ____ Female ____
Single ___ Married ___ Divorced ___ Widowed ___ # Children ____ Ages _____________
Race: White ___ African American ___ Hispanic ___ Asian ___ Other _____________
Preferred Language: English ___ Spanish ___ French ___ German ___ Other ____________
Occupation: _____________________________________ Employer ____________________________
Spouse's Name __________________________________ Employer ____________________________

Whom may we thank for referring you to our office? ____

Insurance Information

Is Insurance through: Self ___ Spouse ____ Parent ____ Other ______________
If not through self, PLEASE complete the following:
Name of Insured ____
Employer of Insured _______________________________________
Social Security of Insured __________________________________
Date of Birth of Insured ____________________________________

I hereby instruct my Insurance Company to pay to Valley Chiropractic Center, PSC the professional or medical expense benefits allowable and otherwise payable under my current policy as payment toward the total charges for services rendered. THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY. This payment will not exceed my indebtedness to the above-mentioned assignee, and I have agreed to pay, in a current manner, any balance of said professional service charges over this insurance payment. I also authorize release of any information pertinent to my case to any insurance company, adjuster, or attorney in this case.
Signature Patient ____________________________________ Date __________________

Signature of Policy Holder if Not Patient _____________________________________

Payment Agreement

I agree and understand that insurance policies are an arrangement between an insurance carrier and myself. I clearly understand and agree that all services rendered me are charged to me and 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 due and payable. Should it become necessary to place my account with a collection agency or an attorney for collections, I agree to be responsible for collection agency and/ or attorney fees.
Patient Signature _________________________________ Date ____________________

General Health Information:

Have you been diagnosed with having

Diabetes	Yes ____	No ____
Asthma	Yes ____	No ____
Cancer	Yes ____	No ____

Smoking Status: Never Smoked ____ Smoke Everyday ___ Smoke Somedays ___ Former Smoker ___

List of any surgeries you may have had: ____

____

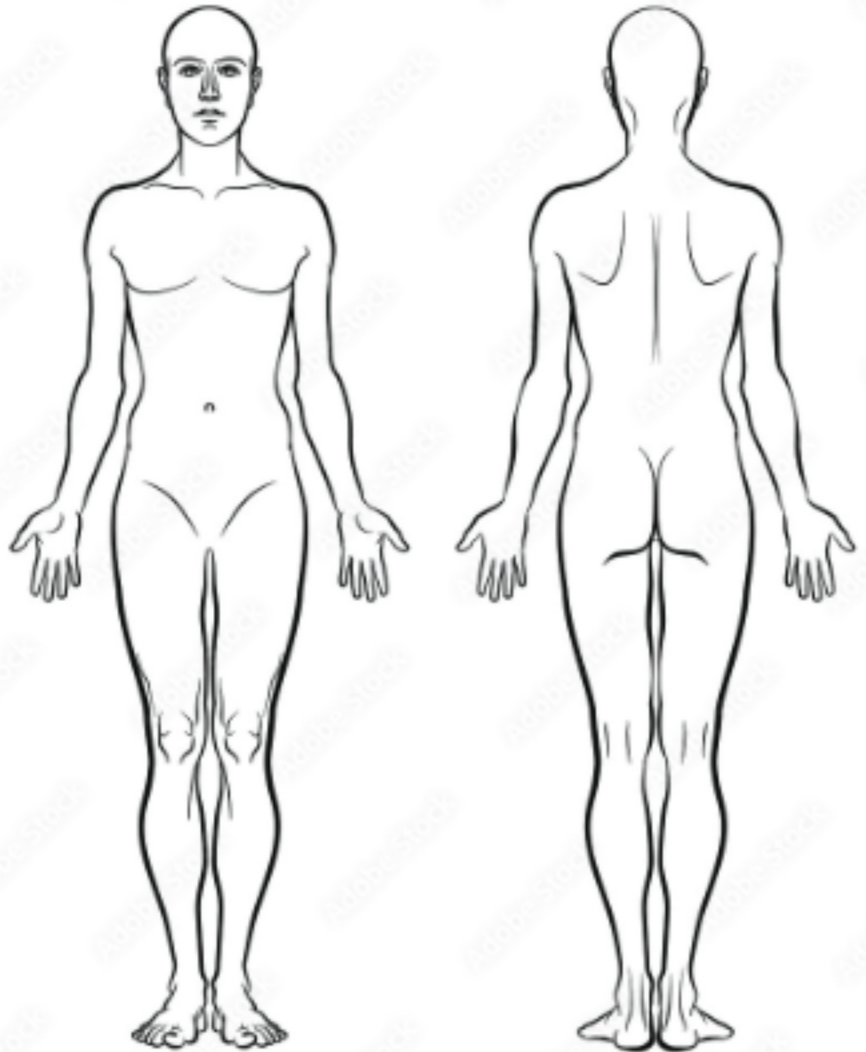
List of any conditions you are seeing another health care provider for: ____________________

____

List any conditions you take medication for: ____

____

Using the symbols below, please indicate on the body images the type of pain or circle the areas you are having problems in.



Type of Pain	Symbol
Sharp	X
Shooting	>
Burning	B
Aching	A
Spasming	S
Tingling	T
Numbness	N

Initial _______