

Rogersville at Riverscape Aric D. Butler D.C. Quentin G. Hendrix D.C. Phone: 256-247-4000 / 256-229-6992 Fax: 256-483-4826

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		Date: /	ENGLISHED TEST	792		
Welcome to	Family Chiropra	ctic! In order for		your heal	thcare nee	eds,
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Patient's Name: Fin	rst	MI_	Last	aansaa yaane saannaana		
Address:		City		_State	Żip	
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Height:	Weight:	Nu	mber of Childre	en:		
Home #	Ce	1#	(wireles	s carrier).		
Work#	Em:	al:				
Would	l you like to recei	ve appointment	reminders? Yes_	1	No	* )
. If y	res (choose only c	ne) Text	or Email_			
Spouse's Name: Fi	rst	MI	Last			
Spouse's Name: Find Spouse's DOB:	//_ Spou	se's SS#:	Spot	ise's Phor	1e #:	4.6
Emergency Contac	ct: Name		Phone #:			
S 4		Patient				
Referred to this of	fice by: Doctor	☐Existing Patien	at DReference's	name		
Primary Care Phys	sician:	2	City/State:			11212
What is the reason	n for this visit?		When did t	his condit	ion begini	)
Is this visit related	to an accident or	a specific event?	□No □Work	□Auto □	Other	
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*	Please indicate	on the diagrams	your area(s) of	discomfor	t.	
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Pain is Durning		⊔sharp O	n a scale of 1-1(	33-4	(N. 17 1200) (222) I	2000
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What ac	tivity is most affected by	v this c	liscomfort	o c				
What ag	gravates the condition?	,		* *************************************			annum e d	
	ANTO ACO MIC COLLMINA							
What tre	eatment have you receive	ved for	this condi	tion?				
Where a	my diagnostic tests perf	ormed	to assess	this condition (	X-ray, N	MRI, CT. e	etc.)P	
in what v	ways does the condition	affect	your life a	nd your ability	to funct	tion?		
Have you	have an additional com	plaintr	_ 1:4: 5	ii aan aa aa aa aa ah aa a		- William Committee		
	u been treated for a sim							
List your	past surgical history						- 1 - 12 - COMMONDAIN	
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List any I	past accidents or trauma	onditio	ns.					
List any I	past accidents or trauma	onditio	ns.					
List any I		onditio	ns.					
List any p	ent medications.	a	ns.					
List any p	ent medications	nesses	that apply					
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List any p	ent medications  te all conditions and illa  Condition  Jaundice	nesses	that apply	. Family refers	to paren			
List any p	ent medications.  te all conditions and ille Condition Jaundice Hepatitis	nesses	that apply	Family refers	to paren	nts, siblings,		
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List any p	ent medications.  te all conditions and ille Condition Jaundice Hepatitis	nesses	that apply	Family refers Condition Diabetes Arthritis Gout	to paren	nts, siblings,		
List any p	cast accidents or traumant medications.  te all conditions and illustration  Condition  Jaundice  Hepatitis  High Blood Pressure	nesses	that apply	Family refers Condition Diabetes Arthritis Gout Alzheimer's	to paren	nts, siblings,		
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List any p	ent medications.  te all conditions and illustration  Jaundice  Hepatitis  High Blood Pressure  Heart Disease  Heart Attack	nesses	that apply	Family refers Condition Diabetes Arthritis Gout Alzheimer's Anemia	to paren	nts, siblings,		
List any p	ent medications  te all conditions and ille Condition Jaundice Hepatitis High Blood Pressure Heart Disease Heart Attack Sickle Cell	nesses	that apply	Family refers Condition Diabetes Arthritis Gout Alzheimer's Anemia Blood Clots	to paren	nts, siblings,		
List any p	ent medications  te all conditions and illustrations  Laundice  Hepatitis  High Blood Pressure  Heart Disease  Heart Attack  Sickle Cell  Scoliosis  HIV/AIDS	nesses	that apply	Family refers Condition Diabetes Arthritis Gout Alzheimer's Anemia Blood Clots Epilepsy	to paren	nts, siblings,		
List curre	ent medications.  te all conditions and ille Condition Jaundice Hepatitis High Blood Pressure Heart Disease Heart Attack Sickle Cell Scoliosis	nesses	that apply	Family refers Condition Diabetes Arthritis Gout Alzheimer's Anemia Blood Clots	to paren	nts, siblings,		

Please indicate any symptom you currently have or have experienced within the past 60 days.    Headache/Migraine	Ple	ease indicate any symptom	VOII CITTE	onthy have or have on		
Concentration/Memory Loss   Back motion restricted   Flushed/pale face   Sensitivity to light   Shoulder pain   Nervousness   Memory loss   Arm pain   Constipation   Nervousness   Arm pain   Constipation   Nervousness   Numbness/tingling in   Nervousness   Numbness/tingling in   Diarrhea   Dizzness   Numbness/tingling in   Diarrhea   Dizzness   Numbness/tingling in   Bruising   Ness of balance   Numbness/tingling in   Bruising   Loss of balance   Numbness/tingling in   Broken Bones   Loss of Late/smel/hearing   Leg   Burry/Double vision   Bruising   Heartpunr/indigestion   Numbness/tingling in   Broken Bones   Loss of Later racing   Blurry/Double vision   Other accident   Heart racing   Blurry/Double vision   Other major procedure   Neck motion restricted   Short of breath   Upper back   Irriability   Naket motion restricted   Short of breath   Upper back   Irriability   Naket motion restricted   Short of breath   Upper back   Irriability   Nature your received chiropractic care before?   Doctor's name    Females: Are you pregnant?   Yes   No   INot sure   Last Period?    Authorization   I certify that I am the patient or legal guardian listed above, and I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be daugerous to my health. I consent to the collection and use of the above information in this office of chiropractic. I authorize this office and its staff to examine and treat my condition as the doctors see fit. I authorize the chiropractor or chiroformation induding the diagnosis and the records of any treatment examination rendered to me or my child during the period of stude hiropractic care to third party payers, insurance company to pay directly to the chiropractor or chiropractic group insurance benefits other		Headache/Migraine	you curre	Mid had of flave experience		n the past 60 days.
Loss   Back motion restricted   Flushed/pale face   Sensitivity to light   Shoulder pain   Nervousness   New your feeling in   Leg pain   Nervousness   Light/Heavy feeling in   Leg pain   Nausea   Numbness/tingling in   Dizziness   Numbness/tingling in   Dizziness   Swelling   Numbness/tingling in   Brusing   Dizziness   Numbness/tingling in   Brusing   Swelling   Numbness/tingling in   Brusing   Dizziness   Numbness/tingling in   Brusing   Dizziness   Numbness/tingling in   Brusing   Dizziness   Numbness/tingling in   Brusing   Dizziness   Numbness/tingling in   Broken Bones   Loss of balance   Numbness/tingling in   Broken Bones   Legs   Surgery   Numbness/tingling in   Broken Bones   Legs   Surgery   Numbness/tingling in   Pain behind eyes   feet   Pail   Auto accident   Fainting   Simus problem   Heart racing   Blurry/Double vision   Other accident   Fainting   Simus problem   Hospitalization   Other major procedure   Neck motion restricted   Short of breath   Upper back   Irritability   Dizziness   Anxiety/depression   What are your current work habits (Occupation, general job description)?    Social Habits?   Alcohol   Tobacco   Illicit Drugs   Present Exercise Habits?   Authorization   I certify that I am the patient or legal guardian listed above, and I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be daugerous to my health. I consent to the collection and use of the above information to this office of chiropractic. I authorize the chiropractor or chiropractic or and the records of any treatment examination rendered to me or my child during the period of such chiropractic care to third party payers, insurance company, attorney, adjuster and/or health practitioners. I grant the use of my signature for required insurance submissions and the records of any treatment examination rendered to me or my child during the period of such chiropractic care to third party payers, i		Concentration/Memory	1600		200	
Sensitivity to light		Loss	_1370	Low back pain/stiffness	200	
Memory loss		Sensitivity to light	14,413			Flushed/pale face
Light/Heavy feeling in   Leg pain   Numbness/tingling in   Diarrhea   Diarrhea   Numbness/tingling in   Diarrhea   Numbness/tingling in   Diarrhea   Numbness/tingling in   Diarrhea   Numbness/tingling in   Brusing   Jaw Pain   Dawn		Memory loss			-	
head			-14/100		7 (200)	
Dizzness   arms   Swelling   Brusing   Brusing   Loss of balance   hands   Jaw Pain   Numbness/tingling in   Brusing   Brusing   hands   Jaw Pain   Numbness/tingling in   Broken Bones   Loss of balance   hands   Numbness/tingling in   Broken Bones   Loss of balance   hands   Numbness/tingling in   Broken Bones   Loss of my almost			1 (1100)			
Ringing in ears   Numbness/tingling in   Brusting   Loss of balance   Loss of balance   Numbness/tingling in   Brusting   Loss of   Save Pain   Broken Bones   Loss of   Numbness/tingling in   Broken Bones   Loss of   Loss of   Numbness/tingling in   Broken Bones   Loss of   Numbness/tingling in   Auto accident   Reart Pacing   Blurry/Double vision   Other accident   Fail   Heart racing   Blurry/Double vision   Other accident   Hospitalization   Neck pain/stiffness   Chest pain   Hospitalization   Other major procedure   Short of breath   Triability   Double of Pain   Hospitalization   Other major procedure   Short of breath   Triability   Double of Pain   Hospitalization   Other major procedure   Short of breath   Triability   Double of Pain   Hospitalization   Other major procedure   Short of breath   Triability   Double of Pain   Hospitalization   Other major procedure   Short of breath   Triability   Double of Pain   Hospitalization   Other major procedure   Short of breath   Triability   Double of Pain   Other major procedure   Short of breath   Triability   Double of Pain   Other major procedure   Short of breath   Triability   Double of Pain   Other major procedure   Short of breath   Triability   Double of Pain   Other major procedure   Short of breath   Triability   Double of Pain   Other major procedure   Short of breath   Triability   Double of Pain   Other major procedure   Short of Pain   Other major procedure   Short of Pain   Other major procedure   Short of Pain   Other major procedure   Double of Pain   Other major procedure   Short of Pain   Other major procedure   Short of Pain   Other major procedure   Double of Pain   Other maj			ш			Contract the same
Loss of balance   hands   Jaw Pain			П		12770	
Loss of   Numbness/tingling in   Broken Bones   Laste/smell/hearing   Legs   Surgery   Numbness/tingling in   Reariburn/midigestion   Numbness/tingling in   Auto accident   Rear racing   Blurry/Double vision   Other accident   Rear racing   Blurry/Double vision   Other accident   Rear racing   Blurry/Double vision   Other accident   Hospitalization   Neck pain/stiffness   Chest pain   Other major procedure   Hospitalization   Other major procedure   Upper back   Urinability   Anxiety/depression   Auxiety/depression   What are your current work habits (Occupation, general job description)?    Social Habits?   Alcohol   Tobacco   Illicit Drugs   Present Exercise Habits?    Have you received chiropractic care before?   Doctor's name    Females: Are you pregnant?   Yes   No   Not sure   Last Period?    Authorization    I certify that I am the patient or legal guardian listed above, and I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I consent to the collection and use of the above information to this office of chiropractic. I authorize this office and its staff to examine and treat my condition as the doctors see fit. I authorize the chiropractor to release any information including the diagnosis and the records of any treatment examination rendered to me or my child during the period of such chiropractic care to third party payers, insurance company, attorney, adjuster and/or health practitioners. I grant the use of my signed statement of authorization with my signature for required insurance submissions. I authorize and request my insurance company to pay directly to the chiropractor or chiropractic group insurance benefits otherwise payable to me. I understand that my chiropractic insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf for my dependents, and pay with		Loss of balance			55.340	
Legs   Broken Bones   Surgery   Heartburn/indigestion   Numbness/tingling in   Auto accident   Fail behind eyes   Feet   Heart racing   Blurry/Double vision   Other accident   Fail   Heart racing   Blurry/Double vision   Other accident   Fail   Heart racing   Blurry/Double vision   Other major procedure   Neck pain/stiffness   Chest pain   Other major procedure   Neck pain/stiffness   Chest pain   Other major procedure   Duper back   Irritability   Irritability   Duper back   Irritability   Anxiety/depression   Have you received chiropractic care before?   Doctor's name   Females: Are you pregnant?   Tyes   No   Not sure   Last Period?   Authorization   I certify that I am the patient or legal guardian listed above, and I have read and understand that providing incorrect information can be dangerous to my health. I consent to the collection and use of the above information to this office of chiropractic. I authorize this office and its staff to examine and treat my condition as the doctors see fit. I authorize the chiropractor to release any information including the diagnosis and the records of any treatment examination rendered to me or my child during the period of such chiropractic care to third party payers, insurance company, attorney, adjuster and/or health practitioners. I grant the use of my signed statement of authorization with my signature for required insurance submissions. I authorize and request my insurance company, attorney, adjuster and/or health practitioners. I grant the use of my signed statement of authorization with my signature for required insurance submissions. I authorize and request my insurance company to pay directly to the chiropractic insurance submissions. I authorize and request my insurance company to pay directly to the chiropractic insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf for my dependents, and pay within a timely matter. I understand and agree that health/accident insuranc			П			
Heartburn/indigestion   Numbness/tingling in   Auto accident   Fall   Auto accident   Fall   Heart racing   Blurry/Double vision   Other accident   Hospitalization   Neck pain/stiffness   Chest pain   Other major procedure   Hospitalization   Other major procedure   Upper back   Irritability   pain/stiffness   Anxiety/depression   Habits?   Alcohol   Tobacco   Illicit Drugs   Present Exercise Habits?      Have you received chiropractic care before?   Doctor's name      Females: Are you pregnant?   Yes   No   Not sure   Last Period?      Authorization   I certify that I am the patient or legal guardian listed above, and I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I consent to the collection and use of the above information to this office of chiropractic. I authorize this office and its staff to examine and treat my condition as the doctors see fit. I authorize the chiropractor to release any information including the diagnosis and the records of any treatment examination rendered to me or my child during the period of such chiropractic care to third party payers, insurance company, attorney, adjuster and/or health practitioners. I grant the use of my signed statement of authorization with my signature for required insurance submissions. I authorize and request my insurance company to pay directly to the chiropractor or chiropractic group insurance benefits otherwise payable to me. I understand that my chiropractic insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf for my dependents, and pay within a timely matter. I understand and agree that health/accident insurance policies are an arrangement between an insurance carrier and myself. I understand that fees for professional services will become immediately due upon suspension or termination of my care or tre			Н			
Pain behind eyes			П	Name Land Control Control		
Heart racing		Pain behind eyes				
Fainting			Ė		1000000	
Neck pain/stiffness   Chest pain   Other major procedure   Neck motion restricted   Short of breath   Uritability   Irritability   Dipper back   Irritability   Irritability   Dipper back   Dipper back   Irritability   Dipper back   Dipper				Blurry/Double vision		
Neck motion restricted Short of breath Upper back Upper back Irritability Pain/stiffness Anxiety/depression  What are your current work habits (Occupation, general job description)?  Social Habits? Alcohol Tobacco Illicit Drugs Present Exercise Habits?  Have you received chiropractic care before? Doctor's name  Females: Are you pregnant? Yes No Not sure Last Period?  Authorization  I certify that I am the patient or legal guardian listed above, and I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I consent to the collection and use of the above information to this office of chiropractic. I authorize this office and its staff to examine and treat my condition as the doctors see fit. I authorize the chiropractor to release any information including the diagnosis and the records of any treatment examination rendered to me or my child during the period of such chiropractic care to third party payers, insurance company, attorney, adjuster and/or health practitioners. I grant the use of my signed statement of authorization with my signature for required insurance submissions. I authorize and request my insurance company to pay directly to the chiropractor or chiropractic group insurance benefits otherwise payable to me. I understand that my chiropractic insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf for my dependents, and pay within a timely matter. I understand and agree that health/accident insurance policies are an arrangement between an insurance carrier and myself. I understand that fees for professional services will become immediately due upon suspension or termination of my care or treatment.						
Upper back   Irritability   Irritability   Anxiety/depression    What are your current work habits (Occupation, general job description)?  Social Habits?	(19011109		Ц	Chest pain		Other major procedure
What are your current work habits (Occupation, general job description)?  Social Habits? □Alcohol □Tobacco □Illicit Drugs Present Exercise Habits?  Have you received chiropractic care before? □ Doctor's name □  Females: Are you pregnant? □Yes □No □Not sure Last Period? □  Authorization  I certify that I am the patient or legal guardian listed above, and I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I consent to the collection and use of the above information to this office of chiropractic. I authorize this office and its staff to examine and treat my condition as the doctors see fit. I authorize the chiropractor to release any information including the diagnosis and the records of any treatment examination rendered to me or my child during the period of such chiropractic care to third party payers, insurance company, attorney, adjuster and/or health practitioners. I grant the use of my signed statement of authorization with my signature for required insurance submissions. I authorize and request my insurance company to pay directly to the chiropractor or chiropractic group insurance benefits otherwise payable to me. I understand that my chiropractic insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf for my dependents, and pay within a timely matter. I understand and agree that health/accident insurance policies are an arrangement between an insurance carrier and myself. I understand that fees for professional services will become immediately due upon suspension or termination of my care or treatment.						450 gm
What are your current work habits (Occupation, general job description)?  Social Habits? □Alcohol □Tobacco □Illicit Drugs Present Exercise Habits?  Have you received chiropractic care before? □ Doctor's name □  Females: Are you pregnant? □Yes □No □Not sure Last Period? □  Authorization  I certify that I am the patient or legal guardian listed above, and I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I consent to the collection and use of the above information to this office of chiropractic. I authorize this office and its staff to examine and treat my condition as the doctors see fit. I authorize the chiropractor to release any information including the diagnosis and the records of any treatment examination rendered to me or my child during the period of such chiropractic care to third party payers, insurance company, attorney, adjuster and/or health practitioners. I grant the use of my signed statement of authorization with my signature for required insurance submissions. I authorize and request my insurance company to pay directly to the chiropractor or chiropractic group insurance benefits otherwise payable to me. I understand that my chiropractic insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf for my dependents, and pay within a timely matter. I understand and agree that health/accident insurance policies are an arrangement between an insurance carrier and myself. I understand that fees for professional services will become immediately due upon suspension or termination of my care or treatment.	-		Manager 1			
Social Habits?   Alcohol   Tobacco   Illicit Drugs   Present Exercise Habits?  Doctor's name  Females: Are you pregnant?   Yes   No   Not sure Last Period?  Authorization  I certify that I am the patient or legal guardian listed above, and I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I consent to the collection and use of the above information to this office of chiropractic. I authorize this office and its staff to examine and treat my condition as the doctors see fit. I authorize the chiropractor to release any information including the diagnosis and the records of any treatment examination rendered to me or my child during the period of such chiropractic care to third party payers, insurance company, attorney, adjuster and/or health practitioners. I grant the use of my signed statement of authorization with my signature for required insurance submissions. I authorize and request my insurance company to pay directly to the chiropractor or chiropractic group insurance benefits otherwise payable to me. I understand that my chiropractic insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf for my dependents, and pay within a timely matter. I understand and agree that health/accident insurance policies are an arrangement between an insurance carrier and myself. I understand that fees for professional services will become immediately due upon suspension or termination of my care or treatment.		partysumess	L.	Anxiety/depression		*
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XSignature of Patient (or parent of minor)	that pro- above in conditionand the chiropra- grant the I author insurance than the for my opolicies	viding incorrect information of a formation to this office of chan as the doctors see fit. I authorize the records of any treatment exercise use of my signed statement rize and request my insurance benefits otherwise payable actual bill for services. I agree dependents, and pay within a are an arrangement between a	gal guardia dge. The a an be dan niropractic orize the c xaminatio s, insuran of authori to me. I un to me. I un to be re timely me	an listed above, and I have reabove questions have been accepted to my health. I consent a little in a little in rendered to me or my characteristic and in rendered to me or my characteristic and with my signature for replaced to pay directly to the chiral and estand that my chiropractic sponsible for payment of all statter. I understand and agree acceptance and myself. I understand that my chiropractic acceptance and myself.	curately as to the cost staff to ormation is and/or equired in operactor of that heal	iswered. I understand llection and use of the examine and treat my including the diagnosis g the period of such health practitioners. I issurance submissions, or chiropractic group the carrier may pay less andered on my behalf th/accident insurance
Signature of Patient (or parent of minor)	X	. 51		,		
	~ ~	Signature of Patient (or par	ent of min	or)		D-4



## Rogersville Family Chiropractic

Aric D. Butler, D.C. 17520 Hwy 72, P.O. Box 219 Rogersville, AL 35652 256-247-4000

## CONTACT INFORMATION SHEET

Patient Name:			
Social Security Number:			
Any physician, staff, employee, or discuss my account and medical comedications, or any other type of p	maining which may make	arroantama beater	ny permission to nosis, test results,
Name	Relationship	Phone #	
Name	Relationship	Phone #	
Name	Relationship	Phone #	
□ Ple	u may leave a detailed mess ase leave a message asking NOT leave a message.	age. me to return your call.	
	ent of the second of the secon		
Signature Name of Patient		Date	t:
Printed Name of Parent/Patient's Rep.	resentative (If Applicable)		
Signature of Parent/Patient's Represen	ntative (If Applicable)		× ,
Employee Witness			