

# **BRADLEY CHIROPRACTIC**

**PATIENT INFORMATION:**

Today's Date: \_\_\_\_\_

Patient's Name: \_\_\_\_\_  
Last First MI

Street Address: \_\_\_\_\_

City, ST, Zip: \_\_\_\_\_

Home Number: \_\_\_\_\_

Birth Date: \_\_\_\_\_

Cell Number: \_\_\_\_\_

Sex: M \_\_\_\_\_ F \_\_\_\_\_ Age \_\_\_\_\_

Single \_\_\_ Married \_\_\_ Widowed \_\_\_ Divorced \_\_\_

SSN: \_\_\_\_\_

Occupation: \_\_\_\_\_

Employer Name: \_\_\_\_\_

Employer Address: \_\_\_\_\_  
\_\_\_\_\_

Employer Phone Number: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_

Emergency Phone Number: \_\_\_\_\_

Email Address: \_\_\_\_\_

Whom may we thank for referring you?  
\_\_\_\_\_

**ACCIDENT INFORMATION:**

Is this condition due to an accident? Y \_\_\_\_\_ N \_\_\_\_\_

Type of accident: Auto \_\_\_ Work \_\_\_ Other \_\_\_

**INSURANCE INFORMATION:**

Who is responsible for account? \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_

Birth Date: \_\_\_\_\_ SSN: \_\_\_\_\_

*(Ins. Cont.)*

Insurance Co: \_\_\_\_\_

Insurance ID #: \_\_\_\_\_

Group #: \_\_\_\_\_

Is patient covered by 2<sup>ND</sup> insurance? Y \_\_\_\_\_ N \_\_\_\_\_

If yes, Cardholder's Name: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_

Insurance Co: \_\_\_\_\_

Birth Date: \_\_\_\_\_ SSN: \_\_\_\_\_

**ASSIGNMENT AND RELEASE:**

I, the undersigned certify that I (or my dependent) have insurance coverage with the above named insurance company and assign directly to Shawn P. Bradley, D.C. all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether paid or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

\_\_\_\_\_  
Responsible Party Signature

\_\_\_\_\_  
Relationship Date

**PATIENT CONDITION:**

Reason for visit: \_\_\_\_\_

When did symptoms appear? \_\_\_\_\_

Is this condition getting worse? Y \_\_\_\_\_ N \_\_\_\_\_

How often do you have this pain? \_\_\_\_\_

Is it constant or come and go? \_\_\_\_\_

Does it interfere with your: Work \_\_\_ Sleep \_\_\_ Other \_\_\_

Activities or movements that are painful to perform:

Sitting \_\_\_ Walking \_\_\_ Standing \_\_\_ Bending \_\_\_ Other \_\_\_