

Live Oak Chiropractic Center

Dr. Adam Schwartz 7212 W. Hwy 71, Ste. B Austin, TX 78735 (512) 288-7100

PLEASE PRINT:

PERSONAL INFORMATION

Name _____ Soc. Sec. No. _____ Date _____
Address _____ City _____ Zip _____
Phone _____ Cell Phone _____ Email _____
Date of Birth _____ Marital Status _____ Sex _____ Age _____ Number of Children _____
Occupation _____ Employer _____
Address _____ City/Zip _____ Phone _____
Name of Spouse _____ Employer _____
Referred By _____

CURRENT HEALTH CONDITION

Purpose of this appointment _____
How did it happen? _____
Today's condition started when? _____
What activities aggravate your condition? _____
What activities lessen your condition? _____
Is the condition worse during certain times of the day? _____
Is this condition interfering with work? _____ Sleep? _____ Routine? _____
Is the condition getting progressively worse? _____
Other doctors seen for this condition _____
Type of treatment _____ Results _____

Habits

<input type="checkbox"/> Alcohol: Type _____ Amount _____	Early morning awakenings _____ Daytime drowsiness _____ Other _____	<input type="checkbox"/> Exercise routine: _____ _____
Diet: Salt intake _____ Fat intake _____ Other _____	<input type="checkbox"/> Smoking: Packs daily _____ How long _____ Interested in stopping? _____	<input type="checkbox"/> Caffeine: Coffee, cups daily _____ Other _____
<input type="checkbox"/> Sleep: Difficulty falling asleep _____ Continuity disturbances _____		

EMERGENCY NOTIFICATION

Name _____
Address _____ City/Zip _____ Phone _____

FINANCIAL AGREEMENT

I am requesting Dr. Schwartz bill my insurance. He accepts assignment and I am responsible for any unpaid balance (pursuant to any contract agreements between Dr. Schwartz and my insurance). Cash payments are due at time of service. I will pay a \$20 fee for any returned checks.

Date _____ Patient's Signature _____

AUTHORIZATION TO RELEASE INFORMATION FOR INSURANCE PURPOSES

I hereby authorize Dr. Schwartz to release any information required in the course of my examination or treatment necessary to satisfy medical insurance claims.

Date _____ Patient's Signature _____