

Rejuvenations Chiropractic Care Center * Dr. Ronald M. Repice, II *Chiropractic Neurologist*

Patient Name _____ DOB _____ SS # _____

Address _____ City _____ State _____ Zip _____

E-Mail Address _____ Sex: Male _____ Female _____ Marital Status (circle) S M D W

Home Phone _____ Cell Phone _____ Seasonal Resident ___ Y ___ N

Employer _____ Wk Phone _____ Emergency _____

Wk Address _____ City _____ State _____ Zip _____

Who Referred you here? _____ **Have you been to a Chiropractor before?** ___ Y ___ N _____

Date of Injury or accident _____ N/A * Auto * Work Comp * Slip & Fall * Other _____

Main Reason For This Visit _____

Has this problem been getting: ___ Better ___ Worse ___ Staying The Same

What makes it better: _____ What makes it worse: _____

Has this condition affected your: ___ Work ___ Home ___ Sleep ___ Digestion ___ Elimination ___ Circulation ___ Nerves

___ Hearing ___ Sitting ___ Walking ___ Standing ___ bending ___ Lifting ___ Riding Other: _____

Date of Last Physical Exam _____ Are you currently Under Medical Care? (circle) Y N Why? _____

Family Physician (Name & Address) _____

List any Allergies You Have (Drugs, Food, Hay Fever, Other) _____

List any Vitamins / Medication You Are Taking _____

Describe Any Condition we should know About _____

List Any Previous Surgeries _____

Attorney's Name (IF Applicable) _____ Phone # _____

Address _____ City _____ State _____ Zip _____

Release of Information: I authorize the physician(s) to release any information acquired during my examination or treatment.

I understand that I am directly & fully responsible to Dr. Ronald M. Repice, D.C. & Rejuvenations for Chiropractic / Medical Services rendered and that this agreement is solely made for Dr. Repice and Rejuvenations additional protection and in consideration of his awaiting payment. Should Collection procedures become necessary, for any reason, to collect the amount due Rejuvenations & Dr. Repice for your treatment, additional charges for attorney's fees & interest will be added to the balance owed for treatment.

I further understand that such payment is not contingent on any settlement, insurance payment, including the balance remaining after payment of possible insurance benefits, judgment, or verdict by which I may eventually recover said Chiropractic / medical Services.

MEDICARE PATIENTS ONLY: Dr. Ronald M. Repice, II, D.C. and Rejuvenations has advised me that some services provided by this office may not be reimbursed by Medicare. Should Medicare deny payment for any of the services provided, I have advised Dr. Repice that I shall be personally responsible for payment to the doctor.

(X) Patient Signature (Patient or Parent/Guardian if a Minor) _____ **Date** _____