Welcome to our NUCCA Practice! We are very excited to help you create health in your life with NUCCA.

NUCCA is a process that starts with the initial visit. The goal of this visit is to determine how your bones are shaped, how they are misaligned, and to correct you to restore structural balance and level the pelvis. We welcome questions during all of your visits; however, if your question requires some research or a detailed answer, we will schedule a separate time to talk with you in person or by phone.

We are including a few forms for you to complete and bring with you on your first visit. Please complete them all prior to arriving for your initial visit. We need to spend the majority of the scheduled time frame examining your spine with posture analysis and taking accurate, NUCCA specific x-rays. The initial visit occurs in two parts:

Visit 1a: Health history and spinal evaluation (approximately 20 minutes)
3 NUCCA specific x-ray views of your head and neck (approximately 1 - 1.5 hours)
(sometimes x-rays need to be repeated in order to get the most accurate information and give you the best NUCCA correction possible)
Marker measurement (approximately 5 minutes)

Visit 1b: Report of X-ray findings (approximately 10 minutes)
Initial NUCCA correction and post spinal evaluation (approximately 20 minutes)
Post NUCCA specific x-rays to make sure you are realigned properly. We may have to repeat the correction and post x-ray process as some people realign more easily and some take more effort. (approximately 30 minutes – 1 hour)
Take home instructions (approximately 10 minutes)
Marker measurement (approximately 5 minutes)

Between parts 1a and 1b the doctor will take 30 or more minutes to analyze your x-rays to determine how to correct you unique to your misalignment. You may schedule 1a and 1b on the same day or on different days. We encourage you to eat a meal before you come to the office and bring snacks with you as you are with us for a long period of time. We have a small refrigerator that you can use and we also provide bottled spring water. There are several restaurants within .5 miles of our office.

To expedite the initial visit, please wear a shirt with no collar, i.e. a T-shirt or scoop-necked shirt and dress comfortably. Also, please wear or bring a pair of shoes that cover your entire heel and that are flat or have a low heel. Please remove any jewelry that is on or near your head and neck before arriving. During the x-ray process, be prepared to remove dentures and removable dental appliances.

Lastly, please do not allow anyone to manipulate or massage your neck 4 days prior to your initial NUCCA visit. We need to x-ray your neck in a settled position to get accurate information and these treatments can cause the nerves and, therefore the muscles and joints to be active for 4 days.

Please sign the attached sheet confirming that you have read and understand the process and requirements of the first visit.

I have read the attached letter and understand the process and the requirements of the initial NUCCA visit at Body in Harmony, PC.

Printed Name_____

Signature_____

Date_____

Body in Harmony, PC
11840 Nicholas St. Suite 102, Omaha, NE 68154

Dr. Marcella Ziska

Current History

Date:_____ Patient Name:_____ Case #:_____

What is your chief complaint?_____

What is the location of your chief complaint?_____

If you have pain, does it travel and to where?_____

When did this issue begin? Date of Onset:_____

What specific event brought it on?_____

Was its onset Sudden or Gradual? (please circle one)

Have you had anything like this before the above date? Dates/Event :_____

Since your symptoms started, have they Increased, Decreased or Stayed the Same? (please circle one if it applies)

Severity: Mild (0,1,2,3) Moderate(4,5,6) Severe (7,8,9,10)

(please put a number in each blank): Min: _____ Max:_____ Now: _____

Please describe your pain: Sharp, Dull, Burning, Ache, Throb, Tingling, or Other words you would use_____

Time: Does the pain occur all the time_____ or does it come and go_____?: (Check one)

Is the pain: **Better, Worse** in the **AM** compared to **Better, Worse** in the **PM**: or about the **Same** throughout the day? (circle appropriate choice)

If you have pain how long does it last when it occurs?:_____

What makes it better?:_____

What makes it worse?:_____

What other Doctors/Health Care Professionals have you seen for this problem?

_____

List medication you take for this condition:_____

List other medication/supplements you are currently taking:_____

_____

Last Physical Exam Date:_____ Blood Pressure History: high, low or normal (circle one)

Have you ever suffered from

o Alcoholism	o Chest Pain/Conditions	oFrequent Urination	o Loss of Balance	o Swollen Joints
o Allergies	o Cold Extremities	o Headache	o Loss of taste	o Tuberculosis
o Anemia	o Constipation Cramps	o Hemorrhoids	o Neck Pain or Stiffness	o Ulcers
o Arteriosclerosis	o Depression	o High Blood Pressure	o Nervousness	o Varicose Veins
o Arthritis	o Diabetes	o Hot Flashes	o Pacemaker	o Venereal Disease
o Asthma	o Digestion Problems	o Irregular Heart Be	o Polio	o Others _____
o Back Pain	o Dizziness	o Irregular Cycle	o Poor Posture	_____
o Breast Lump	o Ear Ringing	o Kidney Infection	o Prostate Trouble	_____
o Bronchitis	o Excessive Menstruation	o Kidney Stones	o Sciatica	_____
o Bruise Easily	o Eye Pain/Difficulties	o Loss of Memory	o Shortness of Breath	_____

Hospitalizations/Surgeries:_____

_____

Accidents (Falls/Auto)_____

_____

Work Hours:_____/Wk Sleep Hours:_____/Night Exercise Hours:_____ /Wk

Type of Exercise:_____

Family Health History (Illnesses, Medications, Deaths)

Mom and her family:_____

Dad and his family:_____

Siblings:_____

Describe what you typically eat for: Brkfst_____ Lunch_____
Supper_____ Snacks_____

What is your intake per day of: Caffeine _____Tobacco _____ H20 oz. _____ Alcohol_____

Dr. Signature:_____

A. Notifier: Body in Harmony, PC

B. Patient Name: **C. Identification Number:**

Advance Beneficiary Notice of Noncoverage (ABN)

NOTE: Medicare may not reimburse for ***the services listed*** below.

Medicare does not reimburse for everything, even some care that you or your health care provider have good reason to think you need. We expect Medicare may not reimburse for ***the services listed*** below.

Services	Reason Medicare May Not Reimburse :	Estimated Cost
Examination **X-rays** **Non spinal treatments or specific Complaints not approved by Medicare**	**Coverage is limited to correction of the spine by manual means and as deemed "medically necessary" per Medicare guidelines.**	**$90** **$325** **$15-$55**

WHAT YOU NEED TO DO NOW:

- Read this notice, so you can make an informed decision about your care.
- Ask us any questions that you may have after you finish reading.
- Choose an option below about whether to receive the **services** listed above.
  Note: If you choose Option 1 or 2, we may help you to use any other insurance that you might have, but Medicare cannot require us to do this.

G. OPTIONS: Check only one box. We cannot choose a box for you.

☐ **OPTION 1.** I want ***the services listed*** above. You will ask to be paid now, but I also want Medicare billed for an official decision on payment, which is sent to me on a Medicare Summary Notice (MSN). I understand that if Medicare doesn't pay, I am responsible for payment, but **I can appeal to Medicare** by following the directions on the MSN**.** If Medicare does pay, you will refund any payments I made to you, less co-pays or deductibles.

☐ **OPTION 2.** I want ***the services listed*** above, but do not bill Medicare. You will ask to be paid now as I am responsible for payment. **I cannot appeal if Medicare is not billed**.

☐ **OPTION 3.** I don't want ***the services listed*** above. I understand with this choice I am **not** responsible for payment, and **I cannot appeal to see if Medicare would pay.**

H. Additional Information:

This notice gives our opinion, not an official Medicare decision. If you have other questions on this notice or Medicare billing, call **1-800-MEDICARE** (1-800-633-4227/**TTY:** 1-877-486-2048). Signing below means that you have received and understand this notice. You also receive a copy.

I. Signature:	J. Date:

Body in Harmony, PC

Dr. Marcella Ziska
Lisa Garrett, MS, GCP
11840 Nicholas St. Ste 102, Omaha, NE 68154
Phone: (402) 614-4201 Fax: (402) 614-4520

Authorization to Release Personal and Health Information

Your personal information and health records at Body in Harmony, PC are completely confidential according to the current HIPAA regulations. In order for us to release any information, we require that you give us **written permission**. By signing this release, you are approving any release of information only to the insurance company that may reimburse for your care and/or to those you specifically write in below.

We are not a participating provider with any insurance company as we choose to be out-of-network. **You are responsible for all fees and agree to pay at the time of each service.** We will file with your insurance company as a courtesy and we request that your insurance company reimburse you directly for any out of network benefits you are due. Insurance companies may or may not reimburse you for any services received in this office on any visit. We do not submit to Medicare as we offer maintenance/wellness care only. Medicare will not reimburse for this type of care.

A copy of this form is available upon request.

Please complete if you allow us to share personal and health information with a specific member of your family, partner, friend, insurance company or health care provider.

Insurance Co Name _____

Name _____Relationship_____

Name _____Relationship_____

Name _____Relationship_____

Name _____Relationship_____

(For additional space, you may use the back of this page.)

You give us permission to thank the person who referred you to Body in Harmony, PC.

Name of Referral Source _____

You give us permission to communicate with you in the following ways:

Text _____ Cell phone voicemail _____

Home phone voicemail _____ Work voicemail _____

Leave message with family member _____ Email _____

Signature of Client_____ Date_____ Case #_____

SYMPTOM SURVEY FORM

Patient _____ Doctor _____ Date _____

Birth Date ___/___/___ Approx Weight _____ Sex: Male ☐ Female ☐

Pulse: Recumbent _____ Standing _____ Vegetarian: Yes ☐ No ☐

Blood pressure: Recumbent _____/_____ Standing _____/_____ Ragland's Test is Positive ☐

INSTRUCTIONS: Fill in only the circles which apply to you.
● ○ ○ MILD symptoms (occurred once or twice last 6 months).
○ ● ○ MODERATE symptoms (occurred once or twice last month).
○ ○ ● SEVERE symptoms (chronic, occurred once or twice last week).
○ ○ ○ **Leave circles BLANK if they don't apply to you!**

	1	2	3	
				GROUP 1
1	○	○	○	Acid foods upset
2	○	○	○	Get chilled often
3	○	○	○	"Lump" in throat
4	○	○	○	Dry mouth-eyes-nose
5	○	○	○	Pulse speeds after meal
6	○	○	○	Keyed up - fail to calm
7	○	○	○	Cut heals slowly
8	○	○	○	Gag easily
9	○	○	○	Unable to relax; startles easily
10	○	○	○	Extremities cold, clammy
11	○	○	○	Strong light irritates
12	○	○	○	Urine amount reduced
13	○	○	○	Heart pounds after retiring
14	○	○	○	"Nervous" stomach
15	○	○	○	Appetite reduced
16	○	○	○	Cold sweats often
17	○	○	○	Fever easily raised
18	○	○	○	Neuralgia-like pains
19	○	○	○	Staring, blinks little
20	○	○	○	Sour stomach often
				GROUP 2
21	○	○	○	Joint stiffness on arising
22	○	○	○	Muscle-leg-toe cramps at night
23	○	○	○	"Butterfly" stomach, cramps
24	○	○	○	Eyes or nose watery
25	○	○	○	Eyes blink often
26	○	○	○	Eyelids swollen, puffy
27	○	○	○	Indigestion soon after meals
28	○	○	○	Always seems hungry; feels "lightheaded" often
29	○	○	○	Digestion rapid
30	○	○	○	Vomiting frequent
31	○	○	○	Hoarseness frequent
32	○	○	○	Breathing irregular
33	○	○	○	Pulse slow; feels "irregular"
34	○	○	○	Gagging reflex slow
35	○	○	○	Difficulty swallowing
36	○	○	○	Constipation, diarrhea alternating
37	○	○	○	"Slow starter"
38	○	○	○	Get "chilled" infrequently
39	○	○	○	Perspire easily
40	○	○	○	Circulation poor, sensitive to cold
41	○	○	○	Subject to colds, asthma, bronchitis
				GROUP 3
42	○	○	○	Eat when nervous
43	○	○	○	Excessive appetite
44	○	○	○	Hungry between meals
45	○	○	○	Irritable before meals
46	○	○	○	Get "shaky" if hungry
47	○	○	○	Fatigue, eating relieves
48	○	○	○	"Lightheaded" if meals delayed
49	○	○	○	Heart palpitates if meals missed or delayed
50	○	○	○	Afternoon headaches
51	○	○	○	Overeating sweets upsets
52	○	○	○	Awaken after few hours sleep - hard to get back to sleep
53	○	○	○	Crave candy or coffee in afternoons
54	○	○	○	Moods of depression - "blues" or melancholy
55	○	○	○	Abnormal craving for sweets or snacks
				GROUP 4
56	○	○	○	Hands and feet go to sleep easily, numbness
57	○	○	○	Sigh frequently, "air hunger"
58	○	○	○	Aware of "breathing heavily"
59	○	○	○	High altitude discomfort
60	○	○	○	Opens windows in closed rooms
61	○	○	○	Susceptible to colds and fevers
62	○	○	○	Afternoon "yawner"
63	○	○	○	Get "drowsy" often
64	○	○	○	Swollen ankles, worse at night
65	○	○	○	Muscle cramps, worse during exercise; get "charley horses"
66	○	○	○	Shortness of breath on exertion
67	○	○	○	Dull pain in chest or radiating into left arm, worse on exertion
68	○	○	○	Bruise easily, "black and blue" spots
69	○	○	○	Tendency to anemia
70	○	○	○	"Nose bleeds" frequent
71	○	○	○	Noises in head, or "ringing in ears"
72	○	○	○	Tension under the breastbone, or feeling of "tightness", worse on exertion
				GROUP 5
73	○	○	○	Dizziness
74	○	○	○	Dry skin
75	○	○	○	Burning feet
76	○	○	○	Blurred vision
77	○	○	○	Itching skin and feet
78	○	○	○	Excessive falling hair
79	○	○	○	Frequent skin rashes
80	○	○	○	Bitter, metallic taste in mouth in mornings
81	○	○	○	Bowel movements painful or difficult
82	○	○	○	Worrier, feels insecure
83	○	○	○	Feeling queasy; headache over eyes
84	○	○	○	Greasy foods upset
85	○	○	○	Stools light colored
86	○	○	○	Skin peels on foot soles
87	○	○	○	Pain between shoulder blades
88	○	○	○	Use laxatives
89	○	○	○	Stools alternate from soft to watery
90	○	○	○	History of gallbladder attacks or gallstones
91	○	○	○	Sneezing attacks
92	○	○	○	Dreaming, nightmare type bad dreams
93	○	○	○	Bad breath (halitosis)
94	○	○	○	Milk products cause distress
95	○	○	○	Sensitive to hot weather
96	○	○	○	Burning or itching anus
97	○	○	○	Crave sweets
				GROUP 6
98	○	○	○	Loss of taste for meat
99	○	○	○	Lower bowel gas several hours after eating
100	○	○	○	Burning stomach sensations, eating relieves
101	○	○	○	Coated tongue
102	○	○	○	Pass large amounts of foul-smelling gas
103	○	○	○	Indigestion 1/2 - 1 hour after eating; may be up to 3-4 hrs.
104	○	○	○	Mucous colitis or "irritable bowel"
105	○	○	○	Gas shortly after eating
106	○	○	○	Stomach "bloating" after eating

1 2 3 **GROUP 7A**

107 ○ ○ ○ Insomnia
108 ○ ○ ○ Nervousness
109 ○ ○ ○ Can't gain weight
110 ○ ○ ○ Intolerance to heat
111 ○ ○ ○ Highly emotional
112 ○ ○ ○ Flush easily
113 ○ ○ ○ Night sweats
114 ○ ○ ○ Thin, moist skin
115 ○ ○ ○ Inward trembling
116 ○ ○ ○ Heart palpitates
117 ○ ○ ○ Increased appetite without weight gain
118 ○ ○ ○ Pulse fast at rest
119 ○ ○ ○ Eyelids and face twitch
120 ○ ○ ○ Irritable and restless
121 ○ ○ ○ Can't work under pressure

GROUP 7B

122 ○ ○ ○ Increase in weight
123 ○ ○ ○ Decrease in appetite
124 ○ ○ ○ Fatigue easily
125 ○ ○ ○ Ringing in ears
126 ○ ○ ○ Sleepy during day
127 ○ ○ ○ Sensitive to cold
128 ○ ○ ○ Dry or scaly skin
129 ○ ○ ○ Constipation
130 ○ ○ ○ Mental sluggishness
131 ○ ○ ○ Hair coarse, falls out
132 ○ ○ ○ Headaches upon arising, wear off during day
133 ○ ○ ○ Slow pulse, below 65
134 ○ ○ ○ Frequency of urination
135 ○ ○ ○ Impaired hearing
136 ○ ○ ○ Reduced initiative

GROUP 7C

137 ○ ○ ○ Failing memory
138 ○ ○ ○ Low blood pressure
139 ○ ○ ○ Increased sex drive
140 ○ ○ ○ Headaches, "splitting or rending" type
141 ○ ○ ○ Decreased sugar tolerance

GROUP 7D

142 ○ ○ ○ Abnormal thirst
143 ○ ○ ○ Bloating of abdomen
144 ○ ○ ○ Weight gain around hips or waist
145 ○ ○ ○ Sex drive reduced or lacking
146 ○ ○ ○ Tendency to ulcers, colitis
147 ○ ○ ○ Increased sugar tolerance
148 ○ ○ ○ Women: menstrual disorders
149 ○ ○ ○ Young girls: lack of menstrual function

GROUP 7E

150 ○ ○ ○ Dizziness
151 ○ ○ ○ Headaches
152 ○ ○ ○ Hot flashes
153 ○ ○ ○ Increased blood pressure
154 ○ ○ ○ Hair growth on face or body (female)
155 ○ ○ ○ Sugar in urine (not diabetes)
156 ○ ○ ○ Masculine tendencies (female)

GROUP 7F

157 ○ ○ ○ Weakness, dizziness
158 ○ ○ ○ Chronic fatigue
159 ○ ○ ○ Low blood pressure
160 ○ ○ ○ Nails weak, ridged
161 ○ ○ ○ Tendency to hives
162 ○ ○ ○ Arthritic tendencies
163 ○ ○ ○ Perspiration increase
164 ○ ○ ○ Bowel disorders
165 ○ ○ ○ Poor circulation
166 ○ ○ ○ Swollen ankles
167 ○ ○ ○ Crave salt
168 ○ ○ ○ Brown spots or bronzing of skin
169 ○ ○ ○ Allergies - tendency to asthma

1 2 3

170 ○ ○ ○ Weakness after colds, influenza
171 ○ ○ ○ Exhaustion - muscular and nervous
172 ○ ○ ○ Respiratory disorders

GROUP 8

173 ○ ○ ○ Apprehension
174 ○ ○ ○ Irritability
175 ○ ○ ○ Morbid fears
176 ○ ○ ○ Never seems to get well
177 ○ ○ ○ Forgetfulness
178 ○ ○ ○ Indigestion
179 ○ ○ ○ Poor appetite
180 ○ ○ ○ Craving for sweets
181 ○ ○ ○ Muscular soreness
182 ○ ○ ○ Depression; feelings of dread
183 ○ ○ ○ Noise sensitivity
184 ○ ○ ○ Acoustic hallucinations
185 ○ ○ ○ Tendency to cry without reason
186 ○ ○ ○ Hair is coarse and/or thinning
187 ○ ○ ○ Weakness
188 ○ ○ ○ Fatigue
189 ○ ○ ○ Skin sensitive to touch
190 ○ ○ ○ Tendency toward hives
191 ○ ○ ○ Nervousness
192 ○ ○ ○ Headache
193 ○ ○ ○ Insomnia
194 ○ ○ ○ Anxiety
195 ○ ○ ○ Anorexia
196 ○ ○ ○ Inability to concentrate; confusion
197 ○ ○ ○ Frequent stuffy nose; sinus infections
198 ○ ○ ○ Allergy to some foods
199 ○ ○ ○ Loose joints

FEMALE ONLY

200 ○ ○ ○ Very easily fatigued
201 ○ ○ ○ Premenstrual tension
202 ○ ○ ○ Painful menses
203 ○ ○ ○ Depressed feelings before menstruation
204 ○ ○ ○ Menstruation excessive and prolonged
205 ○ ○ ○ Painful breasts
206 ○ ○ ○ Menstruate too frequently
207 ○ ○ ○ Vaginal discharge
208 ○ Hysterectomy / ovaries removed
209 ○ ○ ○ Menopausal hot flashes
210 ○ ○ ○ Menses scanty or missed
211 ○ ○ ○ Acne, worse at menses
212 ○ ○ ○ Depression of long standing

MALE ONLY

213 ○ ○ ○ Prostate trouble
214 ○ ○ ○ Urination difficult or dribbling
215 ○ ○ ○ Night urination frequent
216 ○ ○ ○ Depression
217 ○ ○ ○ Pain on inside of legs or heels
218 ○ ○ ○ Feeling of incomplete bowel evacuation
219 ○ ○ ○ Lack of energy
220 ○ ○ ○ Migrating aches and pains
221 ○ ○ ○ Tire too easily
222 ○ ○ ○ Avoids activity
223 ○ ○ ○ Leg nervousness at night
224 ○ ○ ○ Diminished sex drive

List the five main complaints you have in the order of their importance:

1. _____
2. _____
3. _____
4. _____
5. _____

Body in Harmony, PC
11840 Nicholas St. Suite 102, Omaha, NE 68154
Dr. Marcella Ziska

INFORMED CONSENT UNDER NEBRASKA CODE SECTION 44-2816

Body in Harmony, PC, is a Corporation operated by Dr. Marcella Ziska.

Chiropractic is a philosophy, art and science which concerns itself with the relationship between structure, primarily the spine, and function, primarily of the nervous system. This relationship may affect the restoration and preservation of health, however, **it is not our intention to either diagnose or treat a medical condition.** The job of this practice is to identify, reduce and correct the Atlas Subluxation Complex. (Subluxation is described in the next paragraph.) The practice of chiropractic includes many standard examination and testing procedures. This office may utilize some of those procedures for the purpose of documenting the probable presence or absence of a subluxation. These may include physical examination, orthopedic and neurological testing, palpation, specialized instrumentation, and radiology examinations. Physiotherapy and rehabilitation procedures may also be utilized to enhance the healing and/or retaining of certain tissues of the body. Unique to the chiropractic profession is the spinal adjustment.

Adjustments are made by chiropractors to correct spinal and extremity joint subluxations. One of the most common disturbances to the nervous system is the vertebral subluxation. This condition exists where one or more vertebrae are misaligned sufficiently to alter biomechanical motion and cause interference to the nervous system. The primary goal in chiropractic health care is the removal of nerve interference by reducing or eliminating the subluxation.

There are a number of different adjusting techniques we may use in this office. NUCCA will be the primary technique. NUCCA adjustments are performed by hand, generating a non-thrusting force delivered to a specific contact point, in a highly specific manner for the **purpose of reducing and/or eliminating the Atlas Subluxation Complex and helping to level the pelvis and restore body balance**. Other thrusting or non-thrusting adjustments may be utilized by hand or by a hand-guided instrument to joint complexes other than the upper cervical area, to improve biomechanical relationships and remove subluxations as indicated.

Not only should you understand the benefits of chiropractic care in restoring and maintaining good health, but also you should be aware that like all health care procedures, there are some inherent risks and limitations. These are seldom enough to contraindicate care, but should be considered in making the decision to receive chiropractic care. Risks associated with some chiropractic adjusting procedures may include musculoskeletal sprain/strain, neurological deficits, osseous fracture, vertebral artery syndrome, including stroke, resulting in brain damage or perhaps death through complicating factors.

If you have any questions concerning the information provided, please notify the doctor prior to care, and obtain the necessary information to make the best decision about receiving chiropractic care.

AUTHORIZATION FOR CHIROPRACTIC CARE

I have read the above paragraphs and understand the information provided. I have been informed of the nature and purpose of chiropractic care, the possible consequences of that care, the risks of that care, including the risk that chiropractic care may not accomplish the desired objective and the possible risk of receiving no chiropractic care. I acknowledge that no guarantees have been made to me concerning the results of care and treatment. All questions which I have asked have been answered to my satisfaction. Having this knowledge, I knowingly authorize Dr. Ziska of Body in Harmony, PC to proceed with chiropractic care and allow them to share my x-rays with their NUCCA Board Certified doctors/coaches in their pursuit of NUCCA board certification.

_____	_____	_____	_____
DATE	CLIENT/LEGAL GUARDIAN SIGNATURE	CASE#	DOCTOR SIGNATURE

Body in Harmony, PC
11840 Nicholas St. Suite 102
Omaha, NE 68154
Dr. Marcella Ziska

Date:_____

Last Name: _____ First Name:_____ MI__ Nickname:_____

Suffix _____ Sex: M or F (circle one) Date of Birth ___/___/_____

Salutation: Mr., Mrs., Miss., Ms., (circle one)

Address: _____ City _____ State _____ Zip_____

Home Phone ( )_____-_____ Cell Phone: ( )_____-_____ Work Phone ( )_____-_____ Ext:_____

Email:_____Last 4 of SS#_____

If a Minor: Person responsible:
Last Name:_____ First Name: _____ MI____ D.O.B ____/____/_____ Sex M or F
Relationship to patient_____
Address if different from above:_____ City _____ State_____
Zip_____

Insurance Company:_____ ID#_____ Group #_____

Occupation:_____ Name of Spouse_____

How did you hear about us:_____ Family Doctor_____

Nearest relative or friend (not living with you)
Last Name: _____ First Name:_____
Address:_____ City:_____ State: _____ Zip:_____
Home Phone: ( )_____- _____ Cell Phone: ( )_____-_____
Relationship: _____

Previous Chiropractic: Yes____ or No_____ Doctor's Name:_____

What do you expect from receiving your spinal correction at Body in Harmony Chiropractic Center, PC?
Short term goals: _____
Long Term goals: _____

I Authorize Body in Harmony Chiropractic Center, PC to release my client information for insurance purposes.

_____(Signature)

Case #_____

Form 007
Revised 3/4/2019