First Choice Healthcare

550 McQueen Smith Road N • Prattville, AL 36066
Office: (334) 358-0320 • Fax: (334) 358-8923

PERSONAL HISTORY

Date: ______________________ Social Security No.: ______________________

Name: ______________________ Address: ______________________

City: ______________________ State: ______________ Zip: ______________

Home Phone: ______________ Cell Phone: ______________ Carrier ______________

Email Address: ______________________ Birthday: ______________ Age: ______ Sex: M F

Circle one: Married Single Widowed Divorced Separated No. Of Children: ______

Name and No. Of Emergency Contact: ______________________________________

Referring Doctor: ______________________ Patient Employer: ______________________

Who Is Responsible For Your Bill: □ Self □ Spouse □ Workman's Comp. □ Medicare

□ Auto Insurance □ Personal Health Insurance □ Other ______________________

If Insurance, Name of Company: ______________________________________

Policy Number: ______________________________________

Insured Name ______________________________ DOB: ______________________

□ Medicare □ BCBS □ Auto Insurance □ Other ______________________

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that the Doctor's Office will prepare any necessary reports and forms to assist me in collecting from the insurance company and that any amount authorized to be paid directly to the Doctor's Office will be credited to my account on receipt. However, I clearly understand and agree that all services rendered me are changed directly to me and that I am responsible for payment. I also understand and agree that any fee attached to the collection of my balance including attorney's fees are my responsibility. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered me will be immediately due and payable.

I hereby authorize the Doctor to treat my spinal condition as he/she deems appropriate through the use of specific adjustments throughout my spine. The patient also agrees that he/she is responsible for all bills incurred at this office. The Doctor will not be held responsible for any pre-existing medically diagnosed conditions, nor for medical diagnosis.

Patient's Signature **X** ______________________________ Date: ______________________

Guardian or Spouse's
Signature Authorizing Care ______________________________ Date: ______________________

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AUTHORIZATION TO PAY PHYSICAN

I hereby authorize the ____ Insurance Company to assign all benefits for all chiropractic/ physical therapy, medical and surgical expenses allowable, and otherwise payable to me under my current insurance policy, as payment toward the total charges for professional services rendered by:

Dr. Wade G. Clingan
Christopher H. Glover, LPT
550 McQueen Smith Road
Prattville, Al 36066
(334) 358-0320

This payment will not exceed my indebtedness to the above mentioned assignee and I have agreed to pay, in a current manner, any balance of said professional service charges over and above this insurance payment.

Patient's Signature **X** ______________________________ Date: ______________

Patient Name/ Address:____

Patient's Medical History Report

Name:______________________________ **Date:**__________________________

Are you currently, or have you in the past 12 months, had physical therapy at **ANY** facility, including home health? **Yes**__ or **No**__

If Yes, where? (Please include **ANY** nursing care or aides from home health, inpatient and/or outpatient physical or speech therapy visits.)

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MEDICAL HISTORY: (Do you currently have or have you ever been diagnosed with any of the following?)

__Diabetes	__Kidney Disease	__Cancer
__Heart Disease	__Pacemaker/Defibulator	__Hypertension
__COPD/Emphysema	__Stoke/CVA/TIA	__Neuropathy
__Any form of arthritis	__Joint Replacement	__Neck or Back Surgeries

Please list **ANY** allergies you may have:

____

____

Please list any major surgeries that you have had:

____

____

Are you currently pregnant? **Yes**__ or **No**__

Occupation:____

What are the primary activities that you are limited with at this time?

1.____________________ **2.**____________________ **3.**____________________

What activities would you like to be able to return to at the completion of this physical therapy program?

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