



Scott Chiropractic and Wellness

801-546-4500

180 West Gordon Ave, Layton, UT 84041

Confidential Health Information

Patient Update

Patient Name: _____ Soc. Sec. #: _____
 Last First Middle Gender
 Date of Birth: _____ Age: _____ Marital Status: S M W D Number of Children: _____
 Month Day Year
 Home Address: _____
 Street City State ZIP
 Home Phone: _____ *Email Address (we keep private): _____
 Cell Phone: _____ ATT Sprint TMob Veriz _____ Employer: _____
 Work Phone: _____ Work Address: _____ City _____ St Zip _____
 Responsible Party: _____ Relationship: _____ Phone (____) _____
 Last First Middle
 Home Address: _____
 Street City State Zip
ALLERGIES YES NO If yes, list all _____ **PACEMAKER** YES NO **Other ELECTRICAL IMPLANT** YES NO

Major complaint: _____ Date symptoms appeared: _____ What Happened? _____
 Is present condition related to employment? Yes No If yes, date _____ Type of injury: _____
 Is present condition related an auto accident? Yes No If yes, date _____ Type of injury: _____
 Date(s) of Other Falls / Accidents: None _____ What Happened? _____
Check if you have: persistent cough blood in stool or any change in bowel habits non healing sores change in wart or mole
 unexplained weight loss, fever / night sweats change in urinary habits / blood in urine persistent lumps, espec in breast or testicles
 Since my last visit I have been seen by (List all other physician / facilities and SPECIALTIY): None _____
FEMALE: Are you pregnant? Yes No If yes due date _____ *I consent to X-rays if necessary Yes No

Primary Insurance: _____ <input type="checkbox"/> Same <input type="checkbox"/> New	Secondary Insurance: _____ <input type="checkbox"/> Same <input type="checkbox"/> New
Employer Issuing Policy: _____	Employer Issuing Policy: _____
Insurance Address: _____	Insurance Address: _____
Phone: _____	Phone: _____
ID #: _____ Group #: _____	ID #: _____ Group #: _____
This Insurance is under the name of: (Insured Person)	This Insurance is under the name of: (Insured Person)
_____ *Birth Date: _____	_____ *Birth Date: _____

****Nearest Relative NOT LIVING WITH PATIENT:**

Name: _____ Relationship _____
 Phone: (____) _____
 Address: _____ City: _____ State: _____ ZIP: _____

I understand that responsibility for payment for services provided in this office for myself or my dependents is mine, due and payable at time of service unless financial arrangements have been made. I further agree, that if payments are extended beyond 30 days from the date fo first billing to pay 1.5% per month on the unpaid balance (annual rate of 18%) with a minimum of 50 cents per month. I thus waive the Statute of Limitations regarding the physician's right to recover. I/we agree to pay all costs and / or reasonable attorneys fees (not to exceed 50% of total balance due) if any delinquent balance is placed with an agency or attorney for collection of suit.

I hereby authorize and assign all health insurance benefits; including major medical, work comp., personal injury, auto, and any other health plans to which I am entitled to Scott Chiropractic and Wellness. I permit this office to endorse co-issued remittance for the conveyance of credit to my account. I hereby authorize Scott Chiropractic and Wellness to release all information necessary to secure payment. I understand and agree that I am responsible for the charges whether or not paid by said insurance and /or declared not medically necessary by insurance company and/or any review panel.

This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original.

The undersigned hereby authorizes Doctor to take x-rays, perform examination and any other diagnostic aids deemed appropriate by Doctor to make a thorough diagnosis of the patient's health needs. I also authorize Doctor to perform any and all forms of treatment, supplementation and therapy that may be indicated.

How did you hear about our office? _____ Name of person taking information: _____

Responsible Party: _____ Date: _____