

[Redacted]

Patient Name

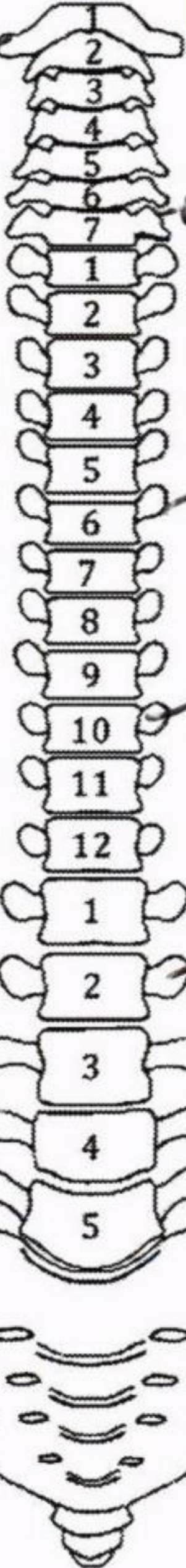
[Redacted]

[Redacted]

Date of Birth

[Redacted]

ASL



Neck

Low back

Headaches



██████ R JONES
ZRW135647963001

Ind Ded **\$500**
Fam Ded **\$1000**
Ind OOP **\$1000**
Fam OOP **\$2000**

Medical, Rx, Den

RxBIN **800001**

RxPCN **██████**

Plan Code **██**

██ OOP \$2500



[REDACTED]

**Providers: Prior Authorization Review
Required**

File claims with your local [REDACTED] and/or Blue Shield Plan.

[REDACTED]

[REDACTED]

YourWyoBlue.com

Member Services: **1-800-442-2376**
Providers: **1-888-359-6592**
Pharmacists: **1-800-424-7094**
TTY: **711**
Dental: **1-844-653-4057**

[REDACTED]

82003-2266

licensee of the Blue
Shield Association

About You



Deines Chiropractic
307-673-5075
1821 S. Sheridan Ave
Unit A
Sheridan, WY 82801

Legal Name: Shalee Jones
Preferred Name: _____
Address: 923 Laclede Street City: Sheridan State: WY Zip: 82801
Cell Phone: 307-461-7252 Home Phone: _____ Email: Shalee.wattona@gmail.com
Birthdate: 11/14/1997 Age: 25 Gender: M ☒ Significant Other: _____
Who referred you? _____ Employer: City Federal _____
Emergency Contact: Austin Jones Phone # 307-751-5351 Have you been to a chiropractor before? No

- I authorize the doctor or his staff to render care as deemed appropriate for me and/or my child
- I authorize Deines Chiropractic to release and/or request records to or from other providers as may be necessary.
- I understand I am responsible for all bills incurred in this office.
- I authorize assignment of my insurance benefits (if applicable) directly to the provider.
- I understand that after any initial promotional services, all care is rendered at usual and customary fees.
- For my balance my preferred payment method is: ☐ Cash ☐ Check ☒ Credit Card

Patient/Parent Signature _____

(This represents a long term authorization for all occasions of service)

Date _____

☐ X-ray okay for minor

Present Complaints

- Back / Hips How long has this been an issue? a while
IS IT: ☐ Dull ☒ Sharp ☒ Ache ☐ Numb/Tingle ☐ Stabbing ☐ Constant ☐ Occasional ☐ Staying the same ☐ Getting worse
☐ Mild ☒ Moderate ☐ Severe Worse in the morning ☐ Worse in the evening Pain radiates to _____
- Back How long has this been an issue? a while
IS IT: ☐ Dull ☒ Sharp ☒ Ache ☐ Numb/Tingle ☐ Stabbing ☐ Constant ☐ Occasional ☐ Staying the same ☐ Getting worse
☐ Mild ☒ Moderate ☐ Severe Worse in the morning ☐ Worse in the evening Pain radiates to _____

How motivated are you to address the root cause of your issues?

0 1 2 3 4 5 6 7 8 9 10
Not Motivated Very Motivated

What is your current condition keeping you from?

What makes it better? _____

What makes it worse? _____

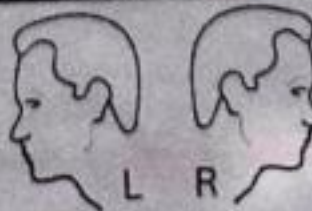
What doctors have you seen for this? _____

Type of Treatment: _____

Results: _____

Are you pregnant?

☐ Yes ☒ No



Please mark all areas of concern

