tiburonwellnesscenter
LOVE YOUR BODY

PATIENT INFORMATION

today's date ____/_____/_____

_____
last name first name

_____
address

_____
city state zip

_____
email

_____/_____/_____ _____ ☐ male ☐ female
date of birth age

☐ single ☐ married ☐ separated ☐ divorced ☐ minor ☐ partnered

_____
occupation

_____
employer / school

_____
employer / school address

_____ ____/_____/_____
spouse's name spouse's date of birth

_____
spouse's employer

_____
whom may we thank for referring you?

CONTACT INFORMATION

home phone (_____)_____

office phone (_____)_____

cell phone (_____)_____

best number to reach you?

☐home ☐office ☐ cell

IN CASE OF EMERGENCY, CONTACT

name_____

relationship _____

home phone (_____)_____

other phone (_____)_____

ACCIDENT INFORMATION

is this condition due to an accident? ☐ yes ☐ no
date of accident _____/_____/_____
type of accident ☐ auto ☐ work ☐ home ☐ other

to whom have you made a report of your accident?
☐ auto insurance ☐ employer ☐ other

attorney name (if applicable)_____
phone (_____)_____

INSURANCE INFORMATION

Who is responsible for this account?_____ Relationship to patient ☐ self ☐ spouse ☐ dependant ☐ other

Insurance Company _____ Policy/ Group _____

ASSIGNMENT AND RELEASE

I certify that I, and/or my dependents, have insurance coverage with_____and assign directly to Tiburon Wellness Center all insurance benefits, If any payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

Tiburon Wellness Center may use my health care information and may disclose such information to the above named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services.

_____ _____
signature of patient / parent / guardian please print name of patient / parent / guardian

____/_____/_____ _____
date relationship to patient

OUR POLICY

Your insurance contract is a contract between you and your insurance company, not between the insurance company and Tiburon Wellness Center. **The total balance on your account is your responsibility** regardless of whether your insurance company pays or not, and **full payment is due at the time of your first visit.**

As a courtesy to our patients we will prepare and submit your insurance forms for direct reimbursement, if we accept assignment of your insurance benefits. However, you are required by law to pay your co-pay,

We require that you keep a current credit card number on file with us at all times. If your insurance company has not paid your account within 45 days, the balance will be automatically transferred to your credit card. A monthly finance charge of 1.5% will be added to unpaid balances after 60 days, accrued from the time of billing.

Unless canceled 24 hours in advance, we reserve the right to charge for missed appointments at the rate of a normal office visit.

_____ _____
Credit Card # for Pre-Authorization / Expiration Date Signature of Card Holder

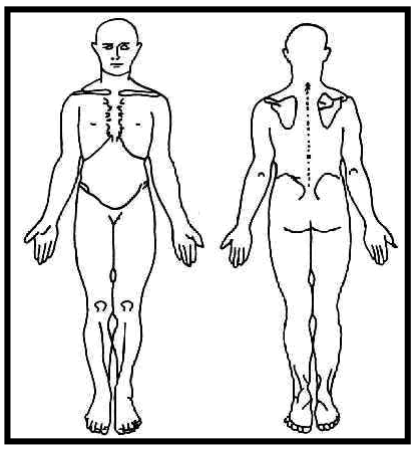
PLEASE CONTINUE ON OTHER SIDE

PATIENT CONDITION

Reason for your visit _____ When did your symptoms appear?_____

Is this condition getting progressively worse? ☐ yes ☐ no ☐ unknown

Indicate on the diagram where you are experiencing: sharp pain (xxx) aching (////)
stabbing (^^^) burning (***)
pins &needles (ooo) shooting (}}})



Rate the severity of your pain on a scale of 1(least pain) to 10(severe pain). _____

Type of pain?

☐ sharp ☐ dull ☐ throbbing ☐ numbness ☐ aching ☐ shooting
☐ burning ☐ cramps ☐ tingling ☐ stiffness ☐ swelling ☐ other

How often to you have the pain? ☐ constant ☐ intermittent ☐ other_____

Does your condition interfere with your? ☐ work ☐ sleep ☐ daily routine ☐ recreation

Painful activities/movements to perform? ☐ sitting ☐ standing ☐ walking ☐ bending ☐ lying down

HEALTH HISTORY

What treatment have you received for your condition? ☐ none ☐ chiropractic ☐ acupuncture ☐ massage ☐ medication ☐ physical therapy

Have you ever received chiropractic care before? ☐ yes ☐ no

Name and address of other doctor(s) who have treated you for this condition_____

Date of last: physical exam_____ spinal x-ray_____ blood test _____
spinal exam _____ chest x-ray_____ urine test _____
dental x-ray _____ MRI/CT _____

Please mark "yes" or "no" to indicate if you have been diagnosed with any of the following:

AIDS/HIV	☐ yes	☐ no	diabetes	☐ yes	☐ no	measles	☐ yes	☐ no	scarlet fever	☐ yes	☐ no
alcoholism	☐ yes	☐ no	emphysema	☐ yes	☐ no	migraines	☐ yes	☐ no	stroke	☐ yes	☐ no
allergy shots	☐ yes	☐ no	epilepsy	☐ yes	☐ no	miscarriage	☐ yes	☐ no	thyroid problems	☐ yes	☐ no
anemia	☐ yes	☐ no	fractures	☐ yes	☐ no	mononucleosis	☐ yes	☐ no	TIA	☐ yes	☐ no
anorexia	☐ yes	☐ no	glaucoma	☐ yes	☐ no	multiple sclerosis	☐ yes	☐ no	tonsillitis	☐ yes	☐ no
appendicitis	☐ yes	☐ no	goiter	☐ yes	☐ no	mumps	☐ yes	☐ no	tuberculosis	☐ yes	☐ no
arthritis	☐ yes	☐ no	gonorrhea	☐ yes	☐ no	osteoporosis	☐ yes	☐ no	tumors / growths	☐ yes	☐ no
asthma	☐ yes	☐ no	gout	☐ yes	☐ no	pacemaker	☐ yes	☐ no	typhoid fever	☐ yes	☐ no
bleeding disorders	☐ yes	☐ no	heart disease	☐ yes	☐ no	parkinson's	☐ yes	☐ no	ulcers	☐ yes	☐ no
breast lump	☐ yes	☐ no	hepatitis	☐ yes	☐ no	pinched nerve	☐ yes	☐ no	vaginal infections	☐ yes	☐ no
bronchitis	☐ yes	☐ no	hernia	☐ yes	☐ no	pneumonia	☐ yes	☐ no	venereal disease	☐ yes	☐ no
bulimia	☐ yes	☐ no	herniated disk	☐ yes	☐ no	polio	☐ yes	☐ no	whooping cough	☐ yes	☐ no
cancer	☐ yes	☐ no	herpes	☐ yes	☐ no	prostate problems	☐ yes	☐ no	OTHER		
cataracts	☐ yes	☐ no	high cholesterol	☐ yes	☐ no	psychiatric condition	☐ yes	☐ no	_____	_____	
chemical dependency	☐ yes	☐ no	kidney disease	☐ yes	☐ no	rheumatoid arthritis	☐ yes	☐ no	_____	_____	
chicken pox	☐ yes	☐ no	liver disease	☐ yes	☐ no	rheumatic fever	☐ yes	☐ no	_____	_____	

EXERCISE ROUTINE ☐ none ☐ moderate ☐ daily

WORK ACTIVITY ☐ sitting ☐ standing ☐ computer ☐ lifting

HABITS
☐ smoking (packs per day) _____
☐ alcohol (drinks per week) _____
☐ coffee/caffeine(cups per day) _____
☐ high stress level (reason) _____

are you pregnant? ☐ yes ☐ no Due Date_____

current medications _____

allergies _____

vitamins / supplements _____

INJURIES / SURGERIES

	Description	date
falls	_____	_____
head injuries	_____	_____
broken bones	_____	_____
dislocations	_____	_____
surgeries	_____	_____
	_____	_____
	_____	_____
	_____	_____

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LOVE YOUR BODY

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy and diagnostic X-rays, on me (or on the patient named below, for whom I am legally responsible) by the doctor of chiropractic named below and/or other licensed doctors of chiropractic who now or in the future work at the clinic or office listed below or any other office or clinic.
I have had an opportunity to discuss with the doctor of chiropractic named below and/or with other office or clinic personnel the nature and purpose of chiropractic adjustments and other procedures. I understand that results are not guaranteed.

I understand and am informed that, as in the practice of medicine, in the practice of chiropractic there are some risks to treatment, including but not limited to fractures, disc injuries, strokes, dislocations and sprains. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely upon the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known to him or her, is in my best interest.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above-named procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

Patient Signature_____ Date _____

Witness Signature _____ Date_____

Name of Treating Physician(s) Gretchen Andreis D.C. Alicia Pflueger, D.C.

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Thank you for choosing TWC as your health care choice.
Our team is committed to providing all of our patients
with the highest quality care.

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We require that you keep a current credit card number on file with us at all times. If your insurance company has not paid your account within 45 days, the balance will be automatically transferred to your credit card. A monthly finance charge of 1.5% will be added to unpaid balances after 60 days, accrued from the time of billing.

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Initial Examination	$100.00 - $175.00
Vertebral Adjustments	$ 45.00 - $ 95.00
Extraspinal Adjustments	$ 35.00
Interseginental Traction	$ 25.00
Ice/Heat Therapy	$ 10.00
Re-Examinations	$ 50.00
Neuromuscular ReEducation	$ 105.00 * $150.00
Other Physical Medicine	$ 47.50
Exercises/Rehabilitation	$ 25.00 - $ 50.00

I have read and understood and agree to the above policy:

_____ _____
Signature of Patient/Guardian Date

_____ _____
Visa or Mastercard Credit Card # Name as it appears on Credit Card

_____ _____
Expiration Date / CVV code on back Signature of Card Holder

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