Eglauf Wellness Center
5 Waller Avenue
White Plains, NY 10601
Patrick Eglauf, D.C

Date: ____________________

Personal Information

Name: ____ **D.O.B:** ______________________

Address: ____ **S.S #:** _______________________

City: _____________________________ **State:** ______ **Zip:** __________________

Email: ____

Gender: M F **Martial Status:** S M D W

Home #: __________________ **Work #:** __________________ **Cell #:** _____________________

Business Employer: ___________________________ **Type of Work:** ______________________

Business Address: ____

City: _____________________________ **State:** _________ **Zip:** ____________________

Insurance Company: ____________________________ **I.D. #:** __________________________

Insured Person's Name: ____

Referred to this office by: ____

Emergency Contact Information

Name: ____ **#:** ____________________________

Relationship: ____

Current Health Condition

Reason for Visit: __________________________________ **When did this begin:** ______________

Have you ever seen any other doctors for this condition? YES NO

Type of treatment: _________________________________ **Results:** _________________________

Are you currently on any medication? If yes, please list:
____

Signature: ____

Medical History

Major surgery/operations? If yes, which? ___________________________When: ____________

Any previous chiropractic care? If yes, name of Doctor and approximate date of last visit:
____

Referring physician: ____

Is an attorney involved in this case? YES NO
Last day worked due to this case: ____

Do you presently or have you had any of the following?

Asthma, Bronchitis, Emphysema	YES	NO	High Blood Pressure	YES	NO
Coronary Heart Diseases or Radiation	YES	NO	Thyroid Trouble/ Goiter	YES	NO
Cancer/Chemotherapy Radiation	YES	NO	Dizziness or Fainting	YES	NO
Emotional/Psychological Problems	YES	NO	Bowel or Bladder Problems	YES	NO
Severe of Frequent Headaches	YES	NO	Infections/Diseases	YES	NO
Vision or Hearing Difficulties	YES	NO	Numbness or Tingling	YES	NO
Sleeping Problems/Difficulties	YES	NO	Elbow Hand Injury/Surgery	YES	NO
Leg/Ankle/Foot injury/Surgery	YES	NO	Neck Injury/Surgery	YES	NO
Any pins or metal implants	YES	NO	Knee Injury/Surgery	YES	NO
Weight/Energy Loss	YES	NO	Arthritis/Swollen Joints	YES	NO
Are you pregnant?	YES	NO	Any varicose veins?	YES	NO
Joint replacement?	YES	NO	Hernia	YES	NO
Allergies?	YES	NO	Weakness	YES	NO
Do you smoke?	YES	NO	Diabetes?	YES	NO
Are you anemic?	YES	NO	Gout	YES	NO
Osteoporosis?	YES	NO	Stroke/T.I.A.	YES	NO
Blood Clot	YES	NO	Epilepsy/Seizures	YES	NO

Please List any other information that will assist the doctor with your care:

Consent for Care and Treatment

I, the undersigned, do hereby agree and give consent for Dr. Patrick Eglauf, D.C to furnish medical care and treatment to ____ considered necessary and proper in diagnosing or treating his/her physical conditions.

Patient/Guardian Signature: ____ Date: ___________

Benefit Assignment/Release of Information

I, hereby assign medical benefits to which I am entitled, including Medicare, private insurance and third party payers to Dr. Patrick Eglauf, D.C. a photocopy of this to be considered as valid as the original. I hereby authorize said assignee to release all information necessary including medical records, to secure payment.

Patient/Guardian Signature: ____ Date: __________

Financial Policy Statement

We will bill your insurance carriers as courtesy to you. We have called your insurance carrier for estimated insurance benefits and they are as follows:

____

____

Your estimated portion is: ____

It is the patient's responsibility to maintain all prescriptions, referrals, and precertification as required by your insurance company. We have called you insurance carrier regarding this and the following are required:

____

____

I have read and understand the above information and I understand my responsibility for the payment of my account.

Patient/Guardian Signature: ____ Date: ________