

MOUNT RAINIER CLINIC PLLC
CONSULTATION (minor) ADMITTANCE
(please print)

CONFIDENTIAL PATIENT INFORMATION

DATE _____

NAME (*minor*) _____

Mother & father's name: _____

ADDRESS _____ CITY/ST/ZIP _____

PHONE parent: (*home*) _____ (*work*) _____ (*cell*) _____

AGE ____ BIRTHDATE ____/____/____ S.S.# ____-____-____

FATHER'S EMPLOYER _____ OCCUPATION _____

EMPLOYER ADDRESS _____ CITY/ST/ZIP _____

MOTHER'S EMPLOYER _____ OCCUPATION _____

EMPLOYER ADDRESS _____ CITY/ST/ZIP _____

REFERRED TO OUR OFFICE BY _____

CHIEF COMPLAINT _____

WHEN DID IT START _____ *is it worse* _____ *same* _____ *better* _____

OTHER DOCTOR(S) SEEN FOR THIS CONDITION _____

DATE OF LAST PHYSICAL EXAM _____ WHERE _____

HIV positive: (*yes*) _____ (*no*) _____ Other conditions _____

Have you been treated for any other health conditions this year? (*yes*) _____ (*no*) _____

What? _____

What SURGERY have you had? *Tonsils* _____ *Appendix* _____ *Gall Bladder* _____ *Hemorrhoids* _____

Vasectomy _____ *Hysterectomy (partial)* _____ (*complete*) _____ *Other surgery* _____

Have you ever had any bad falls? (*yes*) _____ (*no*) _____ *When?* _____

Describe: _____

Have you ever broken any bones? (*yes*) _____ (*no*) _____ *When?* _____

Describe: _____

Have you ever been in a car accident? (*yes*) _____ (*no*) _____ *When?* _____

Describe: _____

What medications or drugs are you taking? _____

List names of other Chiropractors or Naturopaths seen? _____

Name of person responsible for payment? _____

Are you insured? (*no*) _____ (*yes*) _____ Insurance Co: _____ ID # _____

Insured name: _____ Group # _____

**Please show your INSURANCE ID CARD to receptionist.*

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that Mt Rainier Clinic will prepare any necessary reports and forms to assist me in making collection from the insurance company. I clearly understand and agree that all services rendered me that my insurance carrier does not cover I am personally responsible to pay. I further agree to a finance charge of 1% monthly on all past due accounts. PAYMENT IS EXPECTED AT TIME OF VISIT.

PATIENT SIGNATURE _____ DATE ____/____/____

PARENT OR GUARDIAN SIGNATURE _____