

DeVoss Chiropractic Office

489 E. Evelyn Ave
Sunnyvale CA 94086

650 965-7878 Website www.devoss.com

CONFIDENTIAL APPLICATION FOR TREATMENT

Name: _____ Date: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____ Fax: _____

Birth Date: _____ Social Security #: _____ Occupation: _____

E-mail Address: _____

Employer's Name: _____ Address: _____

Sex: _____ Height: _____ Weight: _____ Marital Status: S M D W Sep. # of Children: _____

Name and telephone # of person to contact in an emergency: _____

How did you learn of DeVoss Chiropractic Office? _____

Have you ever had Chiropractic care before? Yes No

Who is or was your regular doctor? Name: _____ Telephone #: _____

PRESENT HISTORY OF COMPLAINT

Please list your present complaint: _____

Are your complaints a result of one of the following (if so, circle one):

Work related injury

Auto Accident

Personal Injury

(If any of the above is circled, see the receptionist for proper paper work.)

Have you acquired an attorney for your complaints? Yes No

If yes, please provide the name and telephone number of your attorney: _____

Do you exercise regularly? _____ Describe: _____

How are your dietary/nutritional habits?(circle one) Excellent Good Adequate Poor

Do you take nutritional supplements? Yes No If so, what do you take? _____

(Office Use: Acct#: _____ Radiographic#: _____)

PAST HISTORY

(This information will help expedite your consultation with the Doctor)

Please list all surgical operations you have had with the year performed: _____
_____ NONE

What, if any, fractures or dislocations have you had and the year: _____
_____ NONE

What, if any, medications are you taking at present: _____
_____ NONE

Please describe any medical condition(s) you have or have had that relate to your overall health status presently:

_____ NONE

Have you been X-Rayed before? Yes No

If so, what parts? _____

Is there a possibility that you are pregnant? Yes No

At the DeVoss Chiropractic Office, we provide goal-oriented treatment for our patients. These goals are measured by the individual patient’s want(s) and need(s). The preliminary focus is to relieve your present complaint(s), but we also offer rehabilitative and supportive care to the individual for the chronic recurring complaint(s) that often are associated with the presenting complaint(s). It is important to us that we provide the treatment which will help you achieve your goals for optimum health. (Circle one)

Relief care only

Rehabilitative care

Supportive Care

Your goal? _____

How will you pay for your services in this office?(circle one) Self Spouse Insurance

(If you are planning to use insurance, please give your card to the receptionist.)

I understand and agree that health and accident insurance policies are an agreement between the insurance company and myself. Furthermore, I understand this chiropractic office will assist me in making claims and collection from my insurance company (is applicable) as a courtesy and that any amount authorized to be paid directly to this office will be credited to my account upon receipt. I clearly understand and agree that all services rendered to me are charged directly to me and I am personally responsible for payment. I also understand that if I suspend or terminate treatment, all fees for professional services will be immediately due and payable.

Dr. DeVoss does not participate in any insurance network as a preferred provider or a managed care physician. Some managed care insurance policies limit or exclude payment for out of network providers. If this is the case, convenient payment plans are available for these necessitated services.

Signature of patient or authorized representative; _____
Date: _____