

IF YOU ARE HERE FOR EITHER A HEALTH ISSUE OR A WELLNESS PROGRAM, PLEASE GIVE US THE FOLLOWING INFORMATION

PLEASE LIST ANY SURGERIES YOU HAVE HAD _____

PLEASE LIST ANY DRUGS OR MEDICATIONS YOU NOW TAKE _____

HAVE YOU RECEIVED CHIROPRACTIC CARE IN THE PAST? _____

WHEN? _____ FOR WHAT PROBLEM? _____

NAME/S OF CHIROPRACTOR/S _____

IF YOU ARE A WOMAN – IS THERE ANY POSSIBLITY YOU ARE PREGNANT?

Y N

IN ORDER TO DETERMINE THE NATURE AND NEED OF MY HEALTH CONCERN AND TO HELP DEVELOP A TREATMENT PLAN, I CONSENT TO A HEALTH HISTORY AND EXAM TO DETERMINE IF MY CONDITION MAY BE HELPED BY DR BLOMERTH.

SIGNATURE _____ DATE _____

I UNDERSTAND THAT ANY X-RAY FILMS TAKEN AT BLOMERTH CHIROPRACTIC REMAIN THE PROPERTY OF THIS CLINIC. IF I WISH A COPY OF THE FILMS FOR MY FILES, A COPY WILL BE PROVIDED AT A NOMINAL FEE WITH NOTICE OF ONE BUSINESS DAY.

SIGNATURE _____ DATE _____



IF YOU ARE HERE FOR A HEALTH ISSUE, PLEASE CONTINUE ON TO NEXT PAGE.

IF YOU ARE HERE FOR WELLNESS CARE PLEASE ANSWER THE FOLLOWING SO WE CAN BETTER SERVE YOU.

PLEASE CHECK ALL THAT APPLY:

ARE YOU INTERESTED IN:

IMPROVING SPORTS OR DAILY ACTIVITY PERFORMANCE? _____

IMPROVING ENERGY..... _____

MAINTAINING /IMPROVING HEALTH GAINS _____

AN INDIVIDUALIZED EXERCISE PROGRAM TO IMPROVE BODY PERFORMANCE/BALANCE/POSTURE/STRENGTH AND ENDURANCE..... _____

NUTRITIONAL INFORMATION/PROGRAM TO OPTIMIZE MY HEALTH.. _____

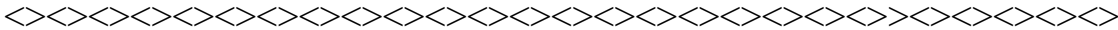
A WEIGHT LOSS PROGRAM TO REACH/MAINTAIN A HEALTHY WEIGHT..... _____

CONSENT TO PAYMENT FOR SERVICES

I understand and agree that health and accident policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that Blomerth Chiropractic will prepare any necessary reports and forms to assist me in making collections from the insurance company and that any amount authorized to be paid directly to Blomerth Chiropractic will be credited to my account on receipt. However, I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment.

I authorize any and all involved insurance companies to pay medical benefits to the undersigned physician for services provided to me.

PATIENT'S SIGNATURE _____ DATE _____
GUARDIAN/PARENT'S SIGNATURE _____ DATE _____
DOCTOR'S SIGNATURE _____ DATE _____

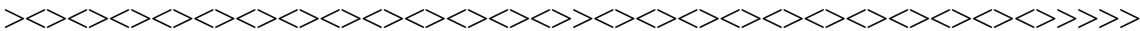


WELLNESS CARE PAYMENT POLICY

I understand that wellness care is not a covered service under most insurance policies. However, if I should ever require care from Blomerth Chiropractic for an injury, and if I should choose to use my insurance coverage to pay for acute care or rehabilitative care, I understand that Blomerth Chiropractic will prepare any necessary reports and forms to assist me in making collections from the insurance company and that any amount authorized to be paid directly to Blomerth Chiropractic will be credited to my account on receipt. However, I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment.

I authorize any and all involved insurance companies to pay medical benefits to the undersigned physician for services provided to me.

PATIENT'S SIGNATURE _____ DATE _____
GUARDIAN/PARENT'S SIGNATURE _____ DATE _____
DOCTOR'S SIGNATURE _____ DATE _____



OFFICE OPERATIONS RELEASE FORM

- 1. I authorize Blomerth Chiropractic to give or send me reminder calls/cards Y N
- 2. I authorize Blomerth Chiropractic to use my name on thank you for referral notes. Y N