

Billauer Family Chiropractic  
2901 Washington Blvd  
Marina Del Rey, CA. 90292  
Ph: (310) 306-1983 FAX: (310) 306-8059

**CONFIDENTIAL PATIENT INFORMATION**

(Please Print Clearly)

Date: \_\_\_\_\_

Name: \_\_\_\_\_

Home Phone: \_\_\_\_\_

Cell Phone: \_\_\_\_\_

Home Address: \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Email Address: \_\_\_\_\_

SSN# \_\_\_\_\_

Occupation: \_\_\_\_\_

Employer: \_\_\_\_\_

Work Address: \_\_\_\_\_

Work Phone: \_\_\_\_\_

Birth Date: \_\_\_\_\_ Age \_\_\_\_\_ Sex: M F Marital Status: S M W D. Spouse's Name \_\_\_\_\_

Names of Children & Ages \_\_\_\_\_

How were you referred to our office? \_\_\_\_\_

Have you ever been to a chiropractor before? \_\_\_\_\_ If so, when? \_\_\_\_\_

List your chief complaints in order of severity: \_\_\_\_\_

1. \_\_\_\_\_ For how long? \_\_\_\_\_

2. \_\_\_\_\_ For how long? \_\_\_\_\_

3. \_\_\_\_\_ For how long? \_\_\_\_\_

List other doctors consulted for these conditions:

1. \_\_\_\_\_

2. \_\_\_\_\_

List the medication(s) you are currently taking:

1. \_\_\_\_\_ 4. \_\_\_\_\_

2. \_\_\_\_\_ 5. \_\_\_\_\_

3. \_\_\_\_\_ 6. \_\_\_\_\_

Cause of complaints/symptoms (Please circle): 1) Work related injury 2) Auto Accident 3) Other

Goal Question: If you could accomplish one important thing or mission for your life, what would that be?

\_\_\_\_\_  
\_\_\_\_\_

PRIMARY INSURANCE: (Group Work Comp Auto Other)

Insurance Co.: \_\_\_\_\_ Name of Insured \_\_\_\_\_

Claim # or Policy #: \_\_\_\_\_ Group #: \_\_\_\_\_

Females: Are you pregnant? Y N Not Sure

***Please notify the doctor if you are pregnant or possible pregnant.***

(Over)

1. ALL FIRST VISIT CHARGES ARE PAYABLE WHEN SERVICES ARE RENDERED
  
2. THE FEE PAID FOR TREATMENT X-RAYS IS FOR ANALYSIS ONLY. THE FILMS ITSELF ARE THE PROPERTY OF THIS OFFICE. ONCE FILMS ARE USED FOR TREATMENT PURPOSES, THEY CANNOT BE RELEASED WITHOUT PROPER WRITTEN REQUEST AND A \$150.00 DEPOSIT.
  
3. METHOD OF PAYMENT YOU PLAN TO USE FOR TODAY'S SERVICES  
CASH      CHECK      CHARGE

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand Dr. Michael Billauer's office 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 Dr. Michael Billauer, D.C., will be credited to my account upon receipt. However, I clearly understand and agree that all services rendered are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate me care at this office, any outstanding charges for professional services rendered will be immediately due and payable. I agree that I will be responsible for all attorney and legal fees of legal action becomes necessary to collect this account. I authorize Billauer Family Chiropractic to obtain a credit report if necessary.

Patient's Signature:

Date:

Guardian or Spouse's Signature for  
Authorized Care:

Date:

In Case of Emergency Notify:

\_\_\_\_\_

Name of nearest relative

\_\_\_\_\_

Relationship

\_\_\_\_\_

Address, City, State

\_\_\_\_\_

Phone Number