Patient Renewal Form

BOWEN CHIROPRACTIC AND WELLNESS CENTER

P.O. Box 366 * 794 South Highway 89

Chino Valley, Arizona 86323 928/636-7682

Date _____ Pt. Number _____

Personal Information

Name	Sex	Marital Status	Date of Birth	Home Phone

Mailing Address	City	State	Zip

Physical Address	City	State	Zip

Social Sec. #	Business Phone Number	Company Name	Location

Spouse's First Name	Phone Number	Spouse's Employer	Location

Emergency contact or nearest relative _____ Phone Number _____

1. My present symptoms are 1. _____( ) 2. _____( )

(pain rating entry) 3. _____( ) 4. _____( )

Overall Pain Rating 1 2 3 4 5 6 7 8 9 10

2. Recent injuries/falls _____

3. Recent surgery _____

4. Recent accident _____

5. Last physical _____

6. Last adjustment or treatment _____ With whom _____

7. Since I last saw you, I have been seen by Dr. _____

For _____

8. Do you have insurance? ☐ Yes ☐ No Company _____

Name of Insured _____ I.D. Number _____ Policy/Group Number _____

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that this office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to this office will be credited to my account upon receipt. I permit this office to endorse co-issued remittances for the conveyance of credit to my account. However, I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. It is my understanding that my credit may be checked if Sound Chiropractic Center extends credit to me and I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered to me will be immediately due and payable unless prior arrangements are made. I hereby authorize the doctors at Sound Chiropractic Center and whomever they may designate as their assistants to administer treatment as they so deem necessary and I also authorize the release of any information acquired in the course of my examination or treatment. I certify that the above information is true and correct.

Patient's Signature _____ Date _____

Parent or Guardian's Signature_____ Print Name _____