Dr. Jacob D. May
223 S 6th Street
Beatrice, NE 68310

Today's Date: _____

Patient Demographic Form

Patient Name: _____ DOB: _____/_____/_____ Age: _____
Social Security #: _____ Marital Status: (S / M / W / D) Sex: (M / F)
Current Address: _____ City: _____ State: _____ Zip: _____
Billing Address (if different): _____ City: _____ State: _____ Zip: _____
Home Phone: (_____)_____ Cell: (_____)_____ Work: (_____)_____
E-mail: _____ Employer: _____

Emergency Contact - Name: _____ Relationship: _____ Phone: _____
How did you hear about us? Sign / website / radio / other / friend or relative. Please list who: _____

We have automated messages for appointment reminders. Please select which you prefer to receive. Default is both.
Text messages (from system phone # 402-382-9401) are sent 2 days and 2 hours prior to your appointment. (Yes / No)
Emails are sent 7 days prior to your appointment. (Yes / No)

Please provide a copy of your insurance card or fill out the following information.

Insurance Carrier: _____ Insurance type: (Commercial / Medicare / Medicaid / Other)
Insured's Name: _____ Policy ID#: _____ Group #: _____
Insured's Birth date: ____/____/____ Relationship to Insured: (Spouse / Child / Other) Insured's Sex: (M / F)
Insured's Employer: _____ Insured's Social Security # _____

I (we) agree to pay for services rendered to the above-mentioned patient as the charge is incurred. I understand and agree that health & accident insurance policies are an arrangement between an insurance carrier and myself and that I am personally responsible for payment of any and all services covered or not covered. I also understand that if I suspend or terminate my care and treatment, any fee for professional services rendered me will be immediately due and payable**.**
Notice to our new patients: Full payment of co-payment for services rendered is due at the end of each visit. If for any reason this request cannot be met, arrangements should be made in advance before seeing the doctor.

We encourage a 24-hour notice if unable to keep your appointment. Please let us know as soon as possible before your appointment time if you are unable to keep your appointment or need to reschedule. Please be on-time or arrive a few minutes early for your appointment. **A $25.00 fee will be charged for NO SHOW and LATE CANCELLED appointments.**

The patient understands and agrees to allow this chiropractic office to use their Patient Health Information for the purpose of treatment, payment, healthcare operations, and coordination of care. We want you to know how your Patient Health Information is going to be used in this office and your rights concerning those records. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your Patient Health Information, we encourage you to read the HIPAA NOTICE that is available to you at the front desk before signing this consent. If there is anyone you do not want to receive your medical records, please inform our office.

Patient's Signature:_____ Date: _____
Parent or Guardian Signature Authorizing Care: _____ Date: _____

Health Inventory

Major Complaint Today: _____
Is this the result of an accident? (Yes / No) If so, ( ) auto ( ) work related ( ) at home ( ) other
Have you ever been in an accident? (Yes / No)
*If you have no symptoms or complaints today and are here for wellness services, please check here: ( )
How long have you had this condition? _____What have you done for it? _____
What aggravates this condition? _____

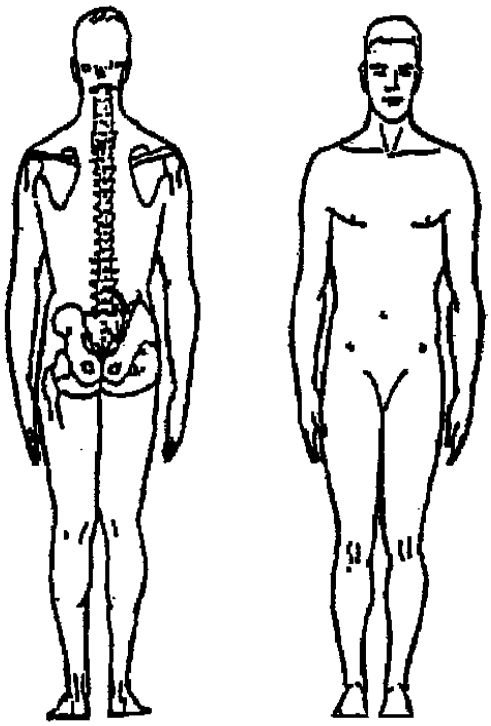
OVER

Have you been treated for any health conditions in the past year? (Yes / No)
If yes, please describe _____
Have you had any previous surgeries or illnesses? (List on separate page if needed.) _____
_____
Do we have your permission to discuss your condition? (Yes / No)
If yes, with whom? _____ Relationship _____
May we share your treatment at Inline Healing with your Primary Care Doctor? (Yes / No)
Primary Care Doctor: _____
Have you had any prior Chiropractic Care? (Yes / No) If so, what were you being treated for? _____
Are you or is there a possibility you are pregnant? Circle one. (Yes / No / N/A)

Have You Ever Suffered From: (check all that apply)

__ Allergy	__ Low Back Pain	__ Poor Circulation	__ Cancer
__ Dizziness	__ Neck Pain or stiffness	__ Asthma	__ Ear Noises
__ Swollen Joints	__ Swelling of ankles	__ Headaches	__ Chest Pain
__ Bruise easily	__ Cramps or backache	__ Spinal curvatures	__ Fatigue
__ Loss of Sleep	__ High Blood Pressure	__ Nervousness/Depression	__ Nausea
__ Difficult digestion	__ Low Blood Pressure	__ Difficult breathing	__ Sciatica
__ Frequent Urination	__ Kidney infection or stone		

Tingling or numbness in: Shoulder___, Arms___, Elbows___, Hands___, Hips___, Legs___, Knees___, Feet___



COMPLETE THESE DIAGRAMS

If you are in pain, please mark the exact location of your pain on the diagram and check the type of pain and frequency of your pain.

_____ Pain	_____ Numbness
_____ Spasm	_____ Sharp
_____ Dull	_____ Tenderness
_____ Constant	_____ Intermediate
_____ Radiates	

Does the pain increase or decrease when:

Sitting	( ) decreases	( ) increases
Standing	( ) decreases	( ) increases
Walking	( ) decreases	( ) increases
Running	( ) decreases	( ) increases
Stretching	( ) decreases	( ) increases

Pain Index: Circle One

Least 1 2 3 4 5 6 7 8 9 10 Worst

How would you describe your overall health? ( ) Good ( ) Fair ( ) Poor
Do you drink alcoholic beverages? (Yes / No) If so, ( ) daily ( ) weekly ( ) monthly
Do you use any tobacco products? (Yes / No) If so, packs per day: _____
Do you consume caffeine products? (Yes / No) If so, how much per day: _____
Do you exercise? (Yes / No) If so, frequency and type of exercise:_____
What percentage of your time during the day do you spend (total should equal 100%):
Standing _____ Lifting _____ Sitting _____ Bending _____ Working at a computer _____