BESSETTE CHIROPRACTIC CLINIC

Dr. Timothy P. Bessette

CONFIDENTIAL PATIENT INFORMATION

Date: _____ Patient Name: _____ Home Phone: _____

Address: _____
Street City State Zip

Email:_____ Cell Phone#:_____Cell Provider:_____

How would you like to be contacted by our office: TEXT EMAIL BOTH

SS#: _____ Age: _____ Date of Birth: / / Marital Status: M S W D

Occupation: _____ Employer: _____

Who may we thank for referring you to us? _____

Reason for appointment & related health problem:	**Date started or for how long?**	**Have you had this before?**	**Injury related?**
1 _____	_____	Yes / No	Yes / No
2 _____	_____	Yes / No	Yes / No

Are you pregnant: Y or N Unsure **Do you have children?** How many: _____ Ages: _____

Medical Doctors or Chiropractors you have seen in the past year:

Name: _____ Condition: _____

Name: _____ Condition: _____

Previous surgeries (please list all types):

Type: _____ Date: _____

Type: _____ Date: _____

Type: _____ Date: _____

Previous accidents or injuries (especially those relate to your present problems):

Type: _____ Date: _____

Type: _____ Date: _____

Type: _____ Date: _____

Insurance Information

Parent or Guardian Name: _____ Phone #:_____

Insured's Name: _____ Phone #: _____

Insured's Date of Birth: / / Insured's Employer: _____

Insured's Address: _____
Street City State Zip

Insured's SS#: _____ Insured's Group Name or #: _____

Name of Insurance Company: _____

Please circle the following conditions you may have had or have now:

Allergy	Alcoholism	Anemia	Arthritis
Back aches	Constipation	Convulsions	Cold Sores
Cancer	Diabetes	Sinus	Venereal Disease
Eczema	Gall Bladder	Heart Attack	High Blood Pressure
Stroke	Epilepsy	Measles	Blood Vessel Disease
Headaches	Heart Disease	Ulcers	Multiple Sclerosis
Neck Pain	Back Pain	Polio	Menstrual Cramps
Mumps	Diarrhea	Whooping Cough	Irregular Periods
Neuritis	Nervousness	Depression	Thyroid Problems
Gout	Pneumonia	Pleurisy	Low Blood Sugar
Malaria	Tuberculosis	Migraine	Miscarriage

Other: _____

Assignment & Release: I authorize release of information to family physicians and employer. I authorize release of information to insurance companies. I authorize the taking of photographs and x-rays to be used for treatment purposes. I authorize the performance of other diagnostic and therapeutic procedures for treatment purposes. I authorize my insurance benefits to be paid directly to **Bessette Chiropractic, P.C. 401-3 E. North Ave. Villa Park, IL. 60181 (630) 782-6637 drtim@bessettechiropractic.com**

At the completion of your examination today, your doctor will be evaluating your history, examination, computerized scans and x-rays (if taken). You will be asked to return for your Report of Findings the next day. You will then also be advised concerning financial arrangements and insurance coverage as appropriate.

PAYMENT POLICIES

PAYMENT FOR SERVICES PROVIDED TODAY ARE DUE AT THE COMPLETION OF YOUR VISIT.

WE ACCEPT CASH, CHECK, VISA, MASTERCARD OR DEBIT CARDS.

FINANCIAL RESPONSIBILITY REMAINS SOLELY WITH THE PATIENT. OUR CLINIC WILL SUBMIT YOUR HEALTH INSURANCE CLAIMS TO YOUR PROVIDER ON YOUR BEHALF. NON-PAYMENT BY YOUR INSURANCE CARRIER WILL RESULT IN PATIENT'S RESPONSIBILITY.

Patient's Signature: _____ Date: _____

Guardian's Signature: _____ Date: _____