UNIVERSITY PARK CHIROPRACIC

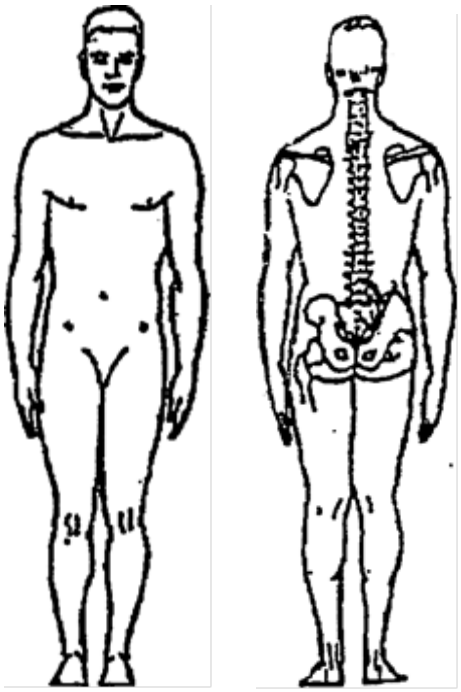
Dr. Kevin D. Hancock, DC

APPLICATION FOR CARE

Name_____ E-mail Address_____ Home Ph._____ Cell Ph._____
Address_____ City_____ State___ Zip_____ Birthdate_____
Marital Status_____ Number of Children___ Employer_____ Occupation_____
Employer Address_____ City_____ State___ Zip_____ Ph._____
Spouse's Name_____ Birthdate_____ Employer_____
Employer Address_____ City_____ State___ Zip_____ Work Ph._____

PLEASE COMPLETE THESE DIAGRAMS

If you are in pain, please mark the exact location of your pain on the diagram. Please describe the type and frequency of your pain as well as any activity which aggravates the pain. _____
_____
_____



Please list any conditions you are currently being treated for or are experiencing. _____
_____
_____
_____

Is your condition due to an accident? If yes, please explain and include the date of the accident. _____
_____
_____

HOW PAYMENT WILL BE MADE

Full 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.

Cash___ Check ___ Credit Card___ Automobile Insurance Policy___ Health Insurance ___ Worker's Comp.___

Do you have Medicare? Yes___ No___ Do you have Medicaid? Yes___ No___

I agree to pay for services rendered to the above mentioned patient as the charge is incurred. I understand and agree that health and accident insurance policies are an arrangement between the 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 the care and treatment, any fee for professional services rendered me will be immediately due and payable.

Patient's Signature_____ Date_____

Guardian Signature if Patient is a Minor_____ Date_____