Berger Chiropractic and Wellness Center
441 S. Federal Highway, Deerfield Beach, Florida 33441

PERSONAL HISTORY

Last Name:_____First Name_____ _____Middle_____

Address:_____Apt #_____

City:_____State_____Zip_____

Date of Birth:_____Age:_____

Social Security Number_____-_____-_____ Sex:_____M_____F____

Circle one: Married - Single - Widowed - Divorced - Separated

Employer:_____Type of Work:_____

Home Phone:(_____)_____Work Phone:(____)_____

Email Address:_____

Spouse Name:_____

HEALTH CONDITION

Reason for this Visit:_____When did this condition begin?_____

What do you expect to gain from today's visit:_____

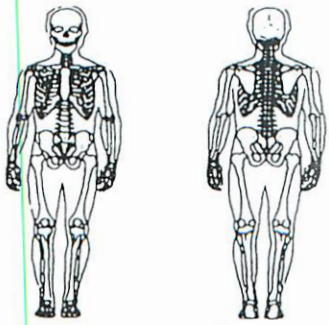
Have you seen any other Doctor's for this condition:_____Who?_____

Have you had any previous surgery? Yes_____No_____

If yes please describe_____

Previous Chiropractic Care: Yes_____No_____Doctor's Name and Last visit_____

PLEASE OUTLINE ON THE DIAGRAM THE AREA OF YOUR DISCOMFORT



I Understand and agree that health and accident insurance policies are and arrangement between the insurance carrier and myself. I understand that verification of benefits is not a guarantee of payment and therefore I am responsible for any and all costs rendered by the Doctor. If I become delinquent in payment of such fees due to the Doctor, I am responsible for any and all collection costs, attorney fees and interest at the maximum legal rate with regards to the recovery of such delinquent account. I also understand that if I suspend or terminate treatment all fees are immediately due and payable.

I hereby authorize the Doctor to treat my condition, as he or she deems appropriate through use of manipulation throughout my spine. I further understand that should the Doctor take x-rays then those x-ray negatives will remain the property of this office, being on file where they may be seen at any time while I am a patient of this office. I also agree that he/she is responsible for all bills incurred at this office. The Doctor will not be held responsible for any pre-existing medically diagnosed conditions, nor for any medical diagnosis.

Patient Signature_____Date_____

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read them or declined the opportunity to read them and understand the Notice of Privacy Practices. I understand that this form will be placed in my patient chart and maintained for six years.

_____ _____

Patient Name (please print) Date

_____

Parent, Guardian or Patient's legal representative

_____

Signature

THIS FORM WILL BE PLACED IN THE PATIENT'S CHART AND MAINTAINED FOR SIX YEARS.