Berger
CHIROPRACTIC and WELLNESS

Last Name: _____ First Name: _____ Middle: _____

Address: _____ APT#: _____

City: _____ State: _____ Zip: _____ Date of Birth: _____

Sex: M F Age: _____ Social Security #: _____

Phone: _____ Cell: _____ email: _____

Marital Status: Single Married Divorced Separated Widowed Partner

Spouse's Name: _____

IN CASE OF EMERGENCY Contact: _____ Relationship: _____ Phone: _____

Occupation: _____ Employer: _____

Employer Address: _____

Employer City: _____ State: _____ Zip: _____

Phone: _____ email: _____

Reason for Visit: _____ When did your symptoms occur? _____

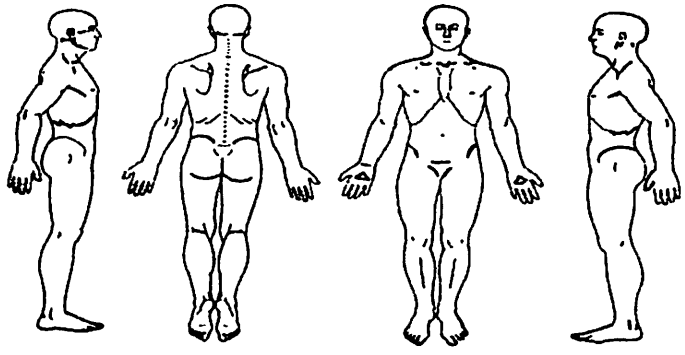
Is condition due to accident? Auto Work Home Other

Is this condition worsening? Y N Have you seen any other doctor for this condition? Y N Who? _____

Have you had any previous surgeries? Y N If yes, please describe _____

Previous Chiropractic Care? Y N Doctor's Name and Last Visit: _____

Mark an X on the diagram where you experience pain



I understand and agree that health and accident insurance policies are an arrangement between the insurance carrier and myself. I understand that the 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's 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 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 any medical diagnosis.

Patient Signature: _____ Date: _____

441 S. Federal Hwy, Deerfield Beach, Florida 33441

Phone: 954-596-8882 Fax: 954-596-8884

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