

**Murphree Chiropractic**  
**New Patient Questionnaire**  
www.DrRodger.com

**Your Appointment is scheduled for** \_\_\_\_\_  
**Fax to 1-205-879-2381. Phone 205-879-2383** (Answer questions to the best of your ability)  
**Is your visit due to an accident?** ( ) Yes ( ) No (If Yes, please complete accident form.)  
**How were you referred to our office?**

\_\_\_\_\_  
**Who is your Primary Care Physician?**

\_\_\_\_\_  
**Do you give your authorization for us to provide your Primary Care Doctor with information regarding this visit as a professional courtesy?**

*Please print when filling in information.*

**LAST** \_\_\_\_\_ **FIRST** \_\_\_\_\_ **MI** \_\_\_ **MALE** \_\_\_ **FEMALE** \_\_\_  
**Street** \_\_\_\_\_ **Social Sec. Number** \_\_\_\_\_  
**City** \_\_\_\_\_ **State** \_\_\_\_\_ **Zip** \_\_\_\_\_  
**Birth** \_\_\_/\_\_\_/\_\_\_ **Age** \_\_\_ **Home Phone**(\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ **Work Phone** \_\_\_ - \_\_\_\_\_  
**Cell Phone** \_\_\_\_\_ **Emergency Phone** \_\_\_\_\_ **Email Address** \_\_\_\_\_

**INSURANCE INFORMATION**

**Company:** \_\_\_\_\_  
**Street** \_\_\_\_\_  
**City** \_\_\_\_\_  
**State** \_\_\_\_\_ **Zip** \_\_\_\_\_  
**Policy #** \_\_\_\_\_  
**Group #** \_\_\_\_\_ **Eff. Date** \_\_\_\_\_  
**Relation** \_\_\_ **Self** \_\_\_ **Spouse** \_\_\_ **Child** \_\_\_ **Other** \_\_\_\_\_

**SECONDARY INSURANCE INFO.**

**Company:** \_\_\_\_\_  
**Street** \_\_\_\_\_  
**City** \_\_\_\_\_  
**State** \_\_\_\_\_ **Zip** \_\_\_\_\_  
**Policy #** \_\_\_\_\_  
**Group #** \_\_\_\_\_

**INSURED INFORMATION**

**Name** \_\_\_\_\_  
**Street** \_\_\_\_\_  
**City** \_\_\_\_\_ **State** \_\_\_\_\_ **Zip** \_\_\_\_\_  
**DOB** \_\_\_\_\_  
**Effective Date** \_\_\_\_\_  
**Your Occupation** \_\_\_\_\_ **Employer** \_\_\_\_\_

**Name** \_\_\_\_\_  
**Street** \_\_\_\_\_  
**City** \_\_\_\_\_ **State** \_\_\_\_\_ **Zip** \_\_\_\_\_

Student- Full Time / Part- Time / NA

**School Name** \_\_\_\_\_  
**Single/ Married/ Other** \_\_\_\_\_ **Number of Children** \_\_\_ **SS#** \_\_\_/\_\_\_/\_\_\_

**Name of Wife/Husband/LegalGuardian** \_\_\_\_\_ **Occupation** \_\_\_\_\_  
**Employer** \_\_\_\_\_ **Birth Date** \_\_\_/\_\_\_/\_\_\_

**Reason for appointment:** \_\_\_\_\_ **When did it start?** \_\_\_\_\_ **Time period?** \_\_\_\_\_ **Injury Related?** \_\_\_\_\_

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_

Briefly describe your current symptoms:

\_\_\_\_\_

**Medical Doctor(s)** consulted within the past year:

Name: \_\_\_\_\_ Condition: \_\_\_\_\_

Name: \_\_\_\_\_ Condition: \_\_\_\_\_

Name: \_\_\_\_\_ Condition: \_\_\_\_\_

**Doctor(s) of Chiropractic** consulted within past year:

Name: \_\_\_\_\_ Condition: \_\_\_\_\_

Name: \_\_\_\_\_ Condition: \_\_\_\_\_

Please list any surgeries that you have had:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Are you **currently taking** any medications? Yes / No – Please list with dosage and strength:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Are you **allergic** to any medications? \_\_\_\_\_

\_\_\_\_\_

Are you pregnant or think you might be pregnant? Yes / No      Date of your last menstrual period: \_\_\_\_\_ Flow? \_\_\_\_\_ Heavy \_\_\_\_\_ Light \_\_\_\_\_ Moderate \_\_\_\_\_ Days

**I, the undersigned patient, hereby authorize the physicians (and appointed staff) to administer such diagnostic testing, procedures, and treatment as are considered necessary on the basis of findings during the course of examination and treatments.**

**I hereby certify that I have read and fully understand the above Authorization to Treat. I also certify that no guarantee or assurance has been made to the results that may be obtained.**

\_\_\_\_\_  
Patients signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Witness signature

\_\_\_\_\_  
Date

**I understand and agree that I am responsible for all financial obligations for all services, supplies and equipment for the above noted patient account. I further understand and agree that if, for any reason, this account could become delinquent I will be responsible for and pay for any and all costs of collection including reasonable attorney fees.**

\_\_\_\_\_  
Patients signature

\_\_\_\_\_  
Date

### Assignment of Benefits

I, \_\_\_\_\_ hereby assign all medical and/or surgical benefits, to include major medical benefits to which I am entitled including Medicare and other government sponsored programs, private insurance and any other private insurance plans for services rendered by Murphree Chiropractic, 2700 Rogers Drive, Suite 204, Homewood, AL 35209. This assignment will remain in effect until revoked by me in writing. **I understand that I am financially responsible for all charges whether or not paid by said insurance.** I hereby authorize said assignee to release all information necessary to secure payment of said benefits.

Signature \_\_\_\_\_ Date \_\_\_\_\_

### Non Coverage Statement

I, \_\_\_\_\_, am aware that there are services that may be rendered that may not be covered by my insurance. This could include services rendered beyond maximum benefits allowed in a calendar year, not medically necessary, etc. **I understand that if services are billed to my insurance and are denied for any reason that I am financially responsible. This includes denials for maximum benefits paid, non-coverage, insurance terminated, applied to deductible, etc.** I understand that my claims are being filed as a courtesy and that any balance that remains is my responsibility.

Signature \_\_\_\_\_ Date \_\_\_\_\_

I, \_\_\_\_\_, am aware that the Nutritional Consult on the first new patient office visit is not covered by insurance and I agree to pay out of pocket that amount on my initial visit.

Signature \_\_\_\_\_ Date \_\_\_\_\_

**Overdue accounts may be placed with a collection agency or attorney for collection. In the event an account is turned over to a collection agency or attorney, the patient or person responsible for patient's account agrees to pay collection charges, attorney's fee, court costs and any other reasonable costs of collection.**

Signature \_\_\_\_\_ Date \_\_\_\_\_