Dr. Ralph G. Ellenberger, Chiropractor
740 West Main Street
Mount Joy, PA 17552
Phone: 717-653-9176 Fax: 717-653-9276

PATIENT INTRODUCTION INFORMATION

(please print)

Date___________Name____
(last) (first) (m.i.)

Address____
(street) (city) (state) (zip code)

Phone #_________________Date of Birth______________Email Address____________________________

Occupation____________________Employer_____________________________Phone#_______________

Employer Address____
(street) (city) (state) (zip)

Marital Status_____M_____S_____W_____D _____No. of Children

Name of Spouse ____
(last) (first) (m.i.)

Spouse's Address____
(street) (city) (state) (zip)

Spouse's DOB:___________Spouse's Employer_____________________________ Phone #_____________

Spouse's Employer Address____
(street) (city) (state) (zip)

Person Responsible for Account____

Referred by_____________________________

FEES ARE PAYABLE WHEN SERVICE RECEIVED UNLESS SPECIAL ARRANGEMENTS MADE.

TYPE OF CARE DESIRED: (please check)

_____I have no specific problem. I understand the role of chiropractic in my general health care.

_____I have a disease or symptom and I am interested in help with this specific problem and in addition, I am interested in learning about my health potential and the role of chiropractic in improving my family's health.

_____I have a disease or symptom and I am interested in help with this problem and in learning how to prevent it in the future.

_____I have a disease or symptom and I am only interested in help with this specific problem.

1. Date of onset____
2. Cause____
3. Location of Pain____
4. Type of Pain____
5. How often are your symptoms present?
   (Intermittent)_____0-25%_____26-50%_____51-75%_____76-100% _____(Constant)
6. What makes pain worse____
7. Relationship to other symptoms____

Previous Treatment:

DC______________________MD/Other______________________Results___________________________

Diagnosis & Type of Treatment____

Have you been placed on disability?______By Whom?____

Health History:

Height____________Weight____________Recent weight gain/loss__________________________________

Important – List of drugs you are now taking____

____

Do you have: _____TB_____VD______In the past_____Cancer_____Diabetes_____Stroke/Heart Problems

_____High Blood Pressure_____Rheumatoid Arthritis

Surgery History: _____Appendix_____Tonsils_____Hernia_____Hemorrhoid_____Spinal_____Hysterectomy

_____Prostate_____Cyst_____Cancer List Others_______________________________

____

Have you had spinal x-rays, MRI, Ct Scan for your area(s) of complaint?_____No_____Yes

Date(s) taken:____________________What areas were taken?_______________________________

List Fractures/Dislocations/Concussions Present & Past____

____

List Previous Accidents/Injuries/Major Illnesses____

____

Family History:

Mother: L________D________Cause____
Father: L________D________Cause____
#____Sisters: L________D________Cause____
#____Brothers: L________D________Cause____
#____Children: L________D________Cause____

Payment Arrangements are expected before services are rendered:

I understand and agree that health and accident Insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that the Chiropractic Office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to the Chiropractic Office will be credited to my account on receipt. However, I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered me will be immediately due and payable.

Twenty-eight days after Statement closing date, I agree to pay the doctor a finance charge computed at the periodic rate of 1½% per month on balances under $1,000.00 and 1% on balances over $1,000.00. Finance charges can be avoided by paying my account balance in full upon receipt of Statement.

PATIENT'S SIGNATURE____Date_____________

Person responsible for payment