

Leone Family Chiropractic

Dr. Chris Leone

Welcome to our office! Our goal is to serve you with the highest quality chiropractic care and treat you like our own family. We look forward to spending the next 30 minutes with you!

NAME: _____ D.O.B. _____ AGE: _____ GENDER: M OR F

ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

HOME#: _____ CELL#: _____ WORK#: _____ SS#: _____

E-MAIL: _____

Your Employer: _____ Full-time/Part-time/Retired

Marital Status: S M W D Your Spouse's Name: _____ Their Employer: _____

Emergency Contact Name & Number: _____

Children Under 18: _____

Health Insurance Company Name/Policy #: _____

Have you ever had chiropractic Care? Y or N How long ago? _____

The purpose of your appointment today? _____

Method of Payment for Visit: Cash Check Credit/Debit _____ (All payment is due @ time of service)

X-RAY CONSENT (ONLY IF NEEDED)

The purpose of the x-ray examination to be performed is to analyze the spine for vertebral subluxations, rate and level of degeneration of the spine, and to determine the appropriateness of spinal adjustments. If the doctor discovers a non-chiropractic (unusual finding) when reviewing the x-rays, I will be informed. I fully understand the above and consent to chiropractic spinal x-rays. *(If you suspect you are pregnant please let the doctor know.)*

** I am familiar with and have viewed the open nature of the Leone Family Chiropractic Facility. I acknowledge that treatment is provided in a setting, which may make my presence and my treatment visible to other persons at the facility. I nevertheless, accept, undertake and consent to the open nature of the treatment facility and hereby waive any privacy violation, which may arise there from. I also understand that a private room is always available to me for consultation with the doctor for private matters concerning my case. **

Please list below 5 of your most significant physical/emotional/chemical stresses and dates of those events
(i.e. Car Accidents/Falls/Medications/Deaths/Divorce's...etc)

***Today's visit** will involve a thorough exam and x-rays if needed, to determine if you have subluxation. For your safety, care will not begin until the doctor has had time to review your findings and determine if your case can be accepted.

*The **second visit** is the Report of Findings in which the doctor will inform you if subluxation exists and to what degree. Should your case be accepted, please allow 45 minutes to adequately describe the nature of your situation and answer any questions you may have. If your case is accepted then you will be adjusted for the first time. **(Payment due @ time of service for the adjustment of \$40.00). \$35 no call no show fee.**

*The **third visit (if your case is accepted)** will consist of a re-check of your spine and the doctor's best recommendation's for the care and correction of your subluxations and spine, **including estimated time of care and cost. Anyone who shares in your healthcare//financial decision-making should be present for this visit. (i.e. spouse/significant other/parent). I further agree that all collection fees/court costs are the responsibility of the patient.**

Patient Signature: _____ Date: _____

Guardian/Parent Signature for Care of Minor: _____ Date: _____