Dr. Thomas Taylor, DC Alaska Healing Touch 951 Bogard Road Suite 103 Wasilla, AK 99654

Phone: 907-631-3673

Patient Information	2 220220 > 0					
Patient Last Name:	Fir	rst Name:			M.I.	
DOB: SSN:		Home Phone:		::		
Mailing Address:		Cell Phone:				
City: State:		Zip Code: E-Mail Addres		ess:	SS:	
Local Contact # (if from out of town):		Marital Status: □ □ Single □ □ Married □□ Divorced □ □ Widowed □ Separated				
Patient Employer:		Patient Occupation:		Work Pho	one:	
Spouse/Partner or Parent Name:		Contact Number:				
Spouse/Partner/Parent Employer:		Work Number:				
Referring Physician:	ry Care Physician:					
Billing Information						
Primary Insurance Company:		Name of Subscriber:			Date of Birth:	
Policy #:		Group #:				
Secondary Insurance Company:		Name of Subscriber: Date of Birth		Date of Birth:		
Policy #:		Group #:				
Ethnicity - Race – Language		1				
Do you consider yourself Hispanic or Latino? □ I am Hispanic or Latino. □ I am not Hispanic or Latino. □ I don't know. □ I decline to answer.	What category best describes your may choose more than one.) White or Caucasian Black or African American Asian Native American or Alaska Nativative Hawaiian or Other Pacification Other Unknown I decline to answer.		ve	What language do you prefer speaking with your health care provider? □ English □ Spanish □ Russian □ Other		
Financial Agreement and Authoriza My signature authorizes treatment and I as plan. I understand that all charges are my time of service. Fees are due and payable i I hereby authorize the release of any in insurance benefits to be paid directly to Al Signature:	gree to pay all fees responsibility rega in full within thirty formation required	and co-payments ardless of insuran (30) days following to process my	ce coverage ar ng the stateme	nd that co-pent closing	pays are due at the date.	
ignature:			Date:			



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On the picture please mark the area with circle where you feel your symptoms such as:		
Pain: P Aches: A Stiffness: S Numbness: N Tingling: T Other: X		6
Do you get headaches? Y N If yes Daily / Weekly / AM / PM Have you experienced any recent trauma? Y / N If yes what type? Auto Accident, Work accident, Home accident and dates?	17-6)	\) {
Have you had any surgeries? Minor or major? Y N If yes please describe:	17/	'1 ^ <i>[</i>
Your Height: Weight: Allergies: Are you taking any medications or supplements? Y / N If yes please list:	_ }}{) {} (
Are you pregnant? Y / N Have you been to a Chiropractor before? Y / N Are you under the care of another doctor for you symptoms or conditions? Y / If yes, name of doctor and for what symptoms / conditions?	- N	

Brief Environmental Questionnaire:

The products and substances and materials listed below are known to cause a variety of common symptoms such as headaches, nausea, irritability, depression, itching, body aches and more. Do you experience any of these symptoms after exposure to the following.

Fragrances such as Hairsprays, Perfumes, Colognes Y/N				
Mold, mildew Y/N				
Soaps, shampoos Y / N				
Household cleaners, bleach, rust remover. Y / N				
Laundry products such as Fabric softeners, Dryer sheets, Detergents Y / N				
Exhaust fumes such Diesel, Gasoline, Propane Y / N				
Dryer vents odors (outside) Y / N				
Air fresheners in cars, restrooms, stores Y / N				
New furniture, Y / N				



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BE INFORMED: Chiropractic does not involve prescription of drugs or medicines, nor the use of surgical procedures. Chiropractic is the clinical science of human health and disease involved with the subluxation complex (SC) and the employment of physiological therapeutic procedures to assist in correction of the SC to enhance the body's inherent recuperative powers. The practice of chiropractic is not an exact science but relies upon information related by the patient and gathered during examination, and the doctor's interpretation thereof, as well as the doctor's judgment, experience, and expertise in working with like cases. In this clinic, all patients are only accepted on a voluntary basis. There is no forced or mandated procedure or treatment; the patient is free to ask questions, decline any specific exam or treatment procedure, therapy, etc. In turn, the Doctor of Chiropractic (DC) is free to decline specific treatment or procedures if the patient elects to refrain from recommended efforts. There is a risk involved in almost all activities, including chiropractic care. No health professional can guarantee a specific result. Each patient should be mindful of his /her own symptoms and should secure medical opinion if concerned as to the nature to the illness or injury. The DC will, of course, provide expert opinion regarding chiropractic conditions. In some cases, underlying, physical defects, deformities, or pathology may render the patient much more susceptible to injury. This is one reason why it is the responsibility of the patient to make it known or to learn about the conditions which may not otherwise come to attention of the DC. There are certain complications which may arise during the course of care, including strains/sprains, dislocation, fractures, disc injury, or cerebral-vascular accidents. These complications are extremely rare occurrences. Such normal procedures as exam and/or X-rays (as needed) will aid your DC in his effort to provide you with the best services for your individual situation. Other techniques, sometimes considered experimental, such as soft tissue work, nutritional methods, etc. may also be recommended or utilized as part of the conservative, non-invasive approach.

PATIENT COMMITMENT: I understand that each patient is a unique individual and will respond as such. I agree that an undesirable result, or side effect, does not necessarily indicate an error in judgment or an improper treatment. I understand that the Doctor will use his hands or an instrument directly upon my body to work soft tissues and to adjust a joint which may or may not cause an audible "pop" or "click". It is not reasonable to expect my Doctor to anticipate, or explain, all possible risks, complications, or details of a given procedure on any particular visit, and I wish to rely on the Doctor to exercise his/her personal professional judgment during the course of any procedures on which he feels at the time is in my best interest. I desire and agree to open and accurate communication between me, the Doctor and staff. I understand there may be alternatives to handling my condition, and I freely choose to participate in the efforts I select at Alaska Healing Touch.

QUESTIONS: The patient should discuss any questions or problems with the doctor before signing this document.

ASSIGNMENT & PROMISE TO PAY DOCTOR: I understand and agree that health and accident insurance policies are an arrangement between insurance carriers and the patient. Furthermore, I understand that this office will help prepare any necessary reports and forms to assist in making collections from my insurance company and I authorize release of all information to third party payers for payment and that payment to be paid directly to this office to be credited to my account on receipt. I hereby irrevocably assign payment directly to the Alaska Healing Touch for expenses otherwise payable to me as determined by the insurance company. I understand that I am personally responsible to the Alaska Healing Touch for all fees that I incur. Authorization to release, at doctor's discretion, any information regarding my case or this claim is also granted. A copy of this document shall be considered as valid as the original.

AGREEMENT & CONSENT: This certifies that I have read, understood and agree to all of the above. I agree and consent to the current normal fee structure in this clinic. I also request and consent to the procedures and treatment(s) to be rendered to myself at Alaska Healing Touch and understand I am to decline or terminate same at any time I clearly make it known to my treating chiropractor.

DATE	PATIENT/PARENT or GUARDIAN SIGNATURE	Print Name