

**PATIENT QUESTIONNAIRE – PAGE 2
Clinic**

Bauman Chiropractic

**3613 North Highway 231
Panama City, FL. 32404**

DATE: _____

PATIENT NAME: _____

Please list the medications that you are currently taking:

_____ Nerve Pills: _____

_____ Pain Killers: _____

_____ Muscle Relaxers: _____

_____ “PEP” Pills: _____

_____ Tranquilizers: _____

_____ Insulin: _____

_____ Birth Control Pills: _____

_____ Diet Pills: _____

_____ Other: (please list) _____

FAMILY PHYSICIAN: _____

ADDRESS : _____ PHONE: _____

DATE LAST SEEN: _____

FINANCIAL ARRANGEMENT:

Fees are payable at the time services are rendered, unless prior arrangements have been made.

ORIGINAL RADIOGRAPHS (X-RAYS) REMAIN PROPERTY OF THIS CLINIC

Patient Signature: _____ Date: _____

Guardian Signature: _____ Date: _____

I understand and agree that health and accident policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that this 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 this office will be credited to my account upon receipt. However, I clearly understand and agree that all services rendered to 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 to me will be immediately due and payable.

Patient Signature: _____ Date: _____

Guardian Signature: _____ Date: _____