Kapsner Chiropractic Centers

Michael A. Kapsner, D.C. • Michael J. Snow, D.C. • James R. Schiffer, D.C. • Christopher Curry, D.C. • Jay A. Heath, D.C. • Dylan J. Payne, D.C.

Personal Information

Name: _____ Birth Date: _____ Age: _____ Sex ☐ F ☐ M

Address: _____ City: _____ State: _____ Zip Code: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Drivers License Number: _____ Social Security Number: _____

Employer: _____ Type of Work: _____

Circle One: Married Single Widowed Divorced Separated

E-mail address: _____

By providing my email, I am allowing the clinic to send me appointment reminders and clinic info.

Names and ages of children: _____

Emergency Contact: _____ Contact Number: _____

Relationship: _____

Who Is Responsible for Your Bill?

☐ You and ☐ Spouse ☐ Worker's Comp ☐ Auto Insurance ☐ Medicare ☐ Medicaid ☐ Attorney

☐ Personal Health Insurance: _____

Policy Number: _____ Group Number: _____

Insured Person's Name: _____ Date of Birth: _____

Primary Care Physician/Clinic Name: _____

Is it Okay to Sent Your Family Care Physician A Written Report: ☐ Yes ☐ No

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and me. Furthermore, I understand that the Doctor's 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 Doctor's office will be credited to my account upon receipt. However, I clearly understand and agree that all services rendered to me are charge directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate, any fees for professional services rendered to me will be immediately due and payable.

I hereby authorize the Doctor to treat my condition as he or she deems appropriate. It is understood and agreed that the amount paid to the Doctor for x-rays is examination only and the x-ray negative will remain property of this office, being on file where they may be seen at any time while a patient of this office. The Patient also agrees that he/she is responsible for all bills incurred at this office.

Patient Signature: _____ Date: _____

Consent to Treat A Minor: _____ Date: _____

Guardian or Spouse's
Signature of Authorizing Care _____ Date: _____

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Current Health Conditions

Name: _____

Unwanted Health Condition: _____
Other Doctors Seen For This Condition? □ Yes □ No Who? _____
Type of Treatment: _____ Results: _____
When Did This Condition Begin? _____
Has This Condition Occurred Before? □ Yes □ No
Is Condition: □ Job Related □ Auto Accident □ Home Injury □ Fall □ Other : _____
Date of Accident: _____ Time of Accident: _____
Drugs You Now Take: □ Nerve Pills □ Pain Killers/Muscle Relaxers □ Blood Pressure Medicine
□ Insulin □ Other: _____
Do You Wear A Shoe Lift? □ Yes □ No
Do You Suffer From Any Condition Other Than That Which You Are Now Consulting Us? _____

PAST HEALTH HISTORY

Major Surgery/Operations: □ Appendectomy □ Tonsillectomy □ Gallbladder □ Hernia
□ Back Surgery □ Broken Bones □ Other: _____
Major Accident or Falls: _____
_____
Hospitalization (Other Than Above): _____
Previous Chiropractic Care: □ None □ Doctor's Name: _____
Approximate Date of Last Visit: _____

MEDICAL HISTORY

(If any of the following are relevant to your medical history, please check the accompanying box.)

□ Cancer	□ Muscular Dystrophy	□ Rheumatic Fever
□ Polio	□ Multiple Sclerosis	□ Scarlet Fever
□ Tuberculosis	□ Convulsions	□ Nervousness
□ High Blood Pressure	□ Epilepsy	□ Asthma
□ Heart Trouble	□ Concussion	□ Digestive Disorders
□ Diabetes	□ Dizziness	□ Sinus Trouble
□ Hepatitis	□ Arthritis	□ Backaches
□ German Measles	□ Neuritis	□ Numbness
□ Venereal Disease	□ Rheumatism	□ Anemia

Most patients that come to our office have one of two objectives in mind concerning their health care. Some patients come for symptomatic relief of pain or discomfort (Relief Care). Others are interested in having the cause of the problem as well as the symptoms corrected and relieved (Corrective Care). Your Doctor will weigh your needs and desires when recommending your treatment program.

Please check the type of care desired so that we may be guided by your wishes whenever possible.

□ **Relief Care** □ **Corrective Care** □ **Check here if you want the Doctor to select the type of care appropriate for your condition.**

_____ _____
Date Patient's Signature

SOUTH AUSTIN: 3005 S. Lamar • Ste, D-112 • Austin • TX • 78704 • 512-441-1240 • Fax 512-441-3762
NORTH AUSTIN: 8440 Burnet Rd. • Ste 118 • Austin • TX • 78757 • 512-459-4014 • Fax 512-459-4017
ROUND ROCK: 2000 S. IH 35 • Suite H1 • Round Rock • TX • 78681 • 512-733-1700 • Fax 512-733-1713
CEDAR PARK: 401 E. Whitestone Blvd. • C-104 • Cedar Park • TX • 78613 • 512-260-4020 • Fax 512-260-4185
BASTROP TEXAS: 1106 College Street • Ste. A • Bastrop • TX • 78062 • 512-985-5486 • Fax 512-985-5477

KAPSNER CHIROPRACTIC CENTERS

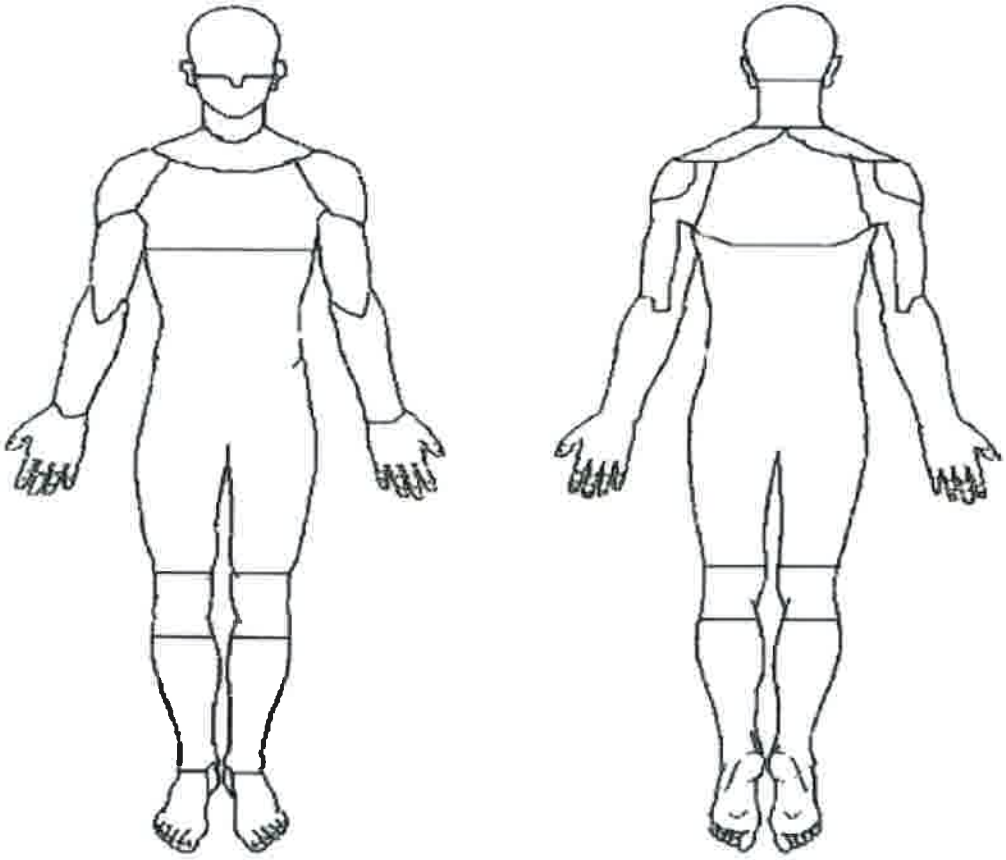
Name _____ Date _____

Nombre Fecha

PAIN DRAWING
DIBUJO DE DOLOR

MARK WHERE YOU HAVE PAIN OR ALTERED SENSATION
MARQUE DONDE SIENTA DOLOR O SENSACION ALTERADA

Pain	Tingling	Burning	Numbness	Stiffness
Dolor	Hormigueo	Ardor	Adormecimiento	Tiesedad



Front

Enfrente

Back

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KAPSNER CHIROPRACTIC

WWW.KAPSNER.COM

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INFORMED CONSENT TO CHIROPRACTIC ADJUSTMENTS AND CARE

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy and diagnostic x-rays, on me (or the patient named below, for whom I am legally responsible) by the doctor of chiropractic named below and/or other licensed doctors of chiropractic who now or in the future treat me while employed by, working, or associated with or serving as back-up for the doctor of chiropractic named below, including those working at the clinic or office listed below or any other office or clinic.

I have had an opportunity to discuss with the doctor of chiropractic named below and/or with other office or clinic personnel the nature and purpose of chiropractic adjustments and other procedures. I understand that results are not guaranteed.

I understand and am informed that, as in the practice of medicine, in the practice of chiropractic there are some risks in treatment, including, but not limited to, fractures, disc injuries, strokes, dislocations and sprains. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely on the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known, is in my best interest.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its content, and by signing below, I agree to the above-named procedures. I intend this consent form to cover the entire course of treatment for my present condition(s) and for any future condition(s) for which I seek treatment.

To be completed by patient or patient's representative, if necessary (e.g., if patient is a minor or is physically or mentally incapacitated):

Print Patient's Name	Patient's Signature	Date

Print name of patient's representative	Signature and relationship of patient's representative

******* To be completed by staff *******

Name and address of clinic (Please check one):

_____3005 S. Lamar, Ste D-112 Austin, TX 78704
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_____8440 Burnet Rd., Ste 118 Austin, TX 78757
_____2000 S. IH 35 Ste H1 Round Rock, TX 78681
_____401 E. Whitestone Blvd. C-104 Cedar Park TX 78613
_____1106 College Street, Ste A Bastrop, TX 78602

Name of Doctor treating this patient

_____Michael Kapsner, D.C.
_____Jay A. Heath, D.C.
_____Michael Snow, D.C.
_____James Schiffer, D.C.
_____Christopher Curry, D.C.
_____Dylan J.Payne, D.C.