

Patient Entrance Form for Drs. Chan, Lyons & Bowness

Name _____ Date _____

Address _____

City _____ Province _____ Postal Code _____

How did you hear about our office? Check all that apply:

Friend _____ Friend's Name _____
Internet _____ Google? _____ Yellowpages.ca? _____ Other _____
Phone Book _____ Passing by _____

Date of Birth D/M/Y _____ Age _____ Male or Female
Telephone: Home _____ Work _____ ext. _____
Cell _____

Email _____

Marital Status: S M D W Sep.

Spouse's Name _____

No. of Children _____

Closest Relative _____ Contact No. _____

Occupation _____

Employer _____

Address _____

Claim will be made against: Motor Vehicle Accident Insurance yes/no

Work related injury/accident yes/no

Health Insurance Benefits yes/no

(please note that we do not direct bill insurance for you)

Medical Doctor's Name _____

Clinic _____

Address _____

Phone _____

Date of last appointment _____

Date of last physical _____

Have you ever had.....?

Measles ___	Chicken Pox ___	Whooping Cough ___	Scarlet Fever ___	Diphtheria ___
Mumps ___	Rheumatic Fever ___	Typhoid Fever ___	Chronic illness ___	Tubes in Ears ___
Aneurysm ___	Osteoporosis ___	Diabetes ___	Arthritis ___	Heart condition ___
Epilepsy ___	Stroke ___	Hepatitis ___	Anxiety ___	Breathing Condition ___
Polio ___	Pneumonia ___	Pleurisy ___	Asthma ___	Sinus Infections ___
Psoriasis ___	HIV/AIDS ___	VD ___	Fatigue ___	
Allergies ___				
Cancer ___				

Have you had previous Chiropractic care?

Name _____ City _____

Name _____ City _____

Results _____

Have you ever had X-rays taken? Yes/No

Who took them _____

Results/findings _____

What medications do you take and why: (include birth control)

Are you a smoker? Yes/No Number of cigarettes per week _____

Do you exercise regularly? If yes, what do you do and for how long _____

Reason for consulting this office _____

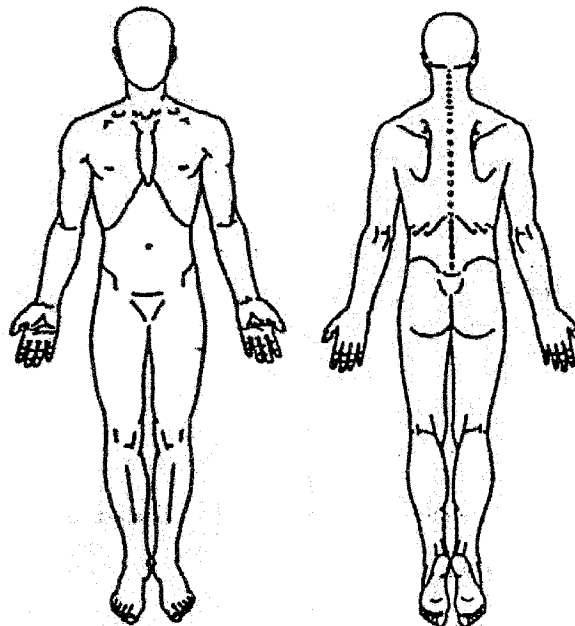
Expectations _____

Draw in your face

Show area(s) of pain or unusual feeling

Mark the areas on this body where you feel the described sensations. Use the appropriate symbols. Mark areas radiation. Include all affected areas.

- Numbness ● ● ● ● ●
- ● ● ● ●
- ● ● ● ●
- Pins & Needles 0 0 0 0 0
- 0 0 0 0 0
- 0 0 0 0 0
- Burning XXXXX
- XXXXX
- XXXXX
- Aching * * * * *
- * * * * *
- * * * * *
- Stabbing / / / / /
- / / / / /
- / / / / /



Dear Patient: Welcome to King West Chiropractic Health Centre!
Please take a few moments to read over our office policy. We will be happy to answer any questions you may have regarding this policy or procedures employed in the clinic.

CLINIC OFFICE POLICY

Clinic Hours: Monday to Friday – 7: 45 am to 6:30 pm

Fee Schedule

<u>Chiropractic:</u>	Fee	Packages:
Initial Examination	75.00	
Subsequent Visit	40.00	12 Visits @ 36.00 x 12 = 432.00 24 Visits @ 34.50 x 24 = 828.00
Student/Senior (Initial Exam.)	55.00	_____
Subsequent Visit	34.00	_____
<u>Acupuncture:</u>		
Initial Examination	75.00	
Subsequent Visit	45.00	12 Visits @ 41.00 x 12 = 492.00
Student/Senior	37.00	
Ultrasound Treatment	15.00	_____

Massage Therapy (GST included):

30min treatment	45.00
45min treatment	65.00
60min treatment	85.00
75min treatment	105.00
90min treatment	120.00

**** All prices subject to change.**

Missed Appointments

**At least 24 hours notice is required when cancelling or rescheduling any appointments.
Patients are responsible for the full fee of any missed appointment without 24 hour notice.**

Insurance

Many benefit plans cover some or all of our services to some extent. While our office does not deal directly with insurance companies, we do issue official receipts which may be submitted for reimbursement.

Privacy Policy

The personal information collected is for limited and confidential use by the clinic. The information is not shared. We reserve the right to contact you on occasion for the following purposes: confirming appointments, clarifying your account and clinic updates/promotions.

Patient Signature: _____ **Date:** _____