



615.373.7009 ◯
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Brentwood Place Shopping Center
330 Franklin Road Suite 266B
Brentwood, Tennessee 37027

NEW PATIENT INFORMATION

Please complete ALL questions below unless otherwise indicated.

First Name _____ Last Name _____ Date _____

Street Address _____ City _____ State _____ Zip _____ Country _____

Phone _____ Fax _____ E-Mail Address _____

Employer _____ Occupation _____

M D S W

Birth Date _____ Age _____ Social Security # _____ Marital Status (circle) _____

Spouse's Name _____ Employer _____ Birth Date _____

Children's Name and Ages: _____

Who may we thank for referring you? _____

Cash Check Credit Card

Name of Insurance Company (if applicable) _____ Method of payment for first visit: _____

CURRENT HEALTH CONCERNS/ REASONS FOR CONSULTING OUR OFFICE:

1. _____ How Long? _____

2. _____ How Long? _____

3. _____ How Long? _____

Have you had the same or similar problem(s) before? Yes No If so, for how long? _____

Is this the result of an auto or work injury? Yes No If so, when? _____

Father, mother, sibling, children with similar problems? Yes No Who? _____

Have you ever been diagnosed with cancer? Yes No What kind? _____

WOMEN ONLY: Is there any chance you are pregnant? Yes No

Other doctors you have seen for this condition: _____

List any surgeries you have had: _____

List any prescription drugs you are taking: _____

PREGNANCY RELEASE

This is to certify that to the best of my knowledge I am not pregnant and that Dr. Bett Gray and Dr. Medina have my permission to perform an x-ray evaluation. I have been advised that x-rays can be hazardous to an unborn child.

Date of last menstrual period: _____

The above information is true and accurate to the best of my knowledge.

Patient of Guardian Signature

Date

Witness

TERMS OF ACCEPTANCE

When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for both to be working towards the same objective. Chiropractic has only one goal. It is important that each patient understand both the objective and the method that will be used to attain it. This will prevent any confusion or disappointment.

ADJUSTMENT: An adjustment is the specific application of forces to facilitate the body's correction of vertebral subluxation. Our Chiropractic method of correction is by specific adjustments of the spine.

HEALTH: A state of optimal physical, mental and social well being not merely the absence of infirmity.

VERTEBRAL SUBLUXATION: A misalignment of one or more of the 24 vertebrae in the spinal column which causes alteration of nerve function and interference to the transmission of mental impulses, resulting in a lessening of the body's innate ability to express maximum health potential. We do not offer to diagnose or treat any disease or condition other than vertebral subluxation. However, if during the course of a chiropractic spinal examination, we encounter non-chiropractic or unusual findings, we will advise you. If you desire advice, diagnosis or treatment for those finding, we will recommend that you seek the services of a health care provider who specializes in that area. Regardless of what the disease is called, we do not offer to treat it. Nor do we offer advice regarding treatment prescribed by others. OUR ONLY PRACTICE OBJECTIVE is to eliminate a major interference to the expression of the body's innate wisdom. Our only method is specific adjusting to correct vertebral subluxations.

CONSENT TO EVALUATE AND ADJUST A MINOR CHILD

I, _____ being the parent or legal guardian of _____
have read and fully understand the above terms of acceptance and hereby grant permission for my child to receive chiropractic care from Dr. Jennifer Bett Gray and Dr. Brenda Medina and whomever they may designate as her assistant(s).

Signature

Date

Witness

CONSENT FOR TREATMENT

I, the undersigned, a patient in this office, hereby authorize Dr. Jennifer Bett, Dr. Brenda Medina (and whomever they may designate as their assistant(s)) to administer treatment as is necessary. I also certify that no guarantee or assurances have been made to me as to the results that may be obtained. I understand and agree that health and accident insurance policies are an agreement between the insurance company and myself. Furthermore, I understand that this office will prepare any necessary reports and forms to assist me in making collection from any insurance company and that any amount authorized to be paid directly to this office will be credited to my account upon receipt. I permit this office to endorse remittances for the conveyance of credit to my account. 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.

Initials:

Date:

Witness

I have read and fully understand the above statements. All questions regarding the doctor's objectives pertaining to my care in this office have been answered to my complete satisfaction. I therefore accept chiropractic care on this basis.

Signature

Date

Witness