

Patient Name: _____

WELCOME

The doctor and staff of **Functional Health Concepts** welcome you and want to provide you with the best possible care. We will conduct a thorough history and physical examination to decide if we can assist you. If we do not believe that your condition will respond to functional chiropractic care, we will not accept you as a patient but will refer you to another health care provider, if appropriate.

PAYMENT

Payment is expected as services are rendered unless prior financial arrangements have been made. A cancellation charge will be made for broken appointments **unless 24 hours notice** is given.

PATIENT IDENTIFICATION

_____	Name or Nickname I prefer to be called
Name _____	in this office _____
_____	Telephone (Home) _____
Street _____	(Work) _____
_____	Ok to call there? Yes () No ()
City, State and Zip _____	_____
_____	Occupation _____
Social Security # _____	_____
Male () Female () _____	Date of Birth _____ Age _____
Contact in case of emergency, Name: _____	_____
Telephone # _____	_____
Name of Parent of Minor Patient (If applicable) _____	_____

ACCEPTANCE AS PATIENT

I understand and agree that **Dr. Michael Dworkin** has the right to refuse to accept me as a patient at any time before treatment begins. The taking of a history and the conducting of a physical examination are not considered treatment, but are part of the process of information gathering so that the doctor can determine whether to accept me as a patient.

Date

Signature