MARCON CHIROPRACTIC & WELLNESS CENTER

David J. Marcon, DC, CCSP

463 Ohio Pike, Suite 104 Cincinnati Ohio 45255

Please Print

Date: _____ Home Phone: (_____)_____ Cell Phone: (_____)_____

Cell Phone Carrier: VZW, SPRINT, METRO, ATT, TMOBILE, BOOST, CINGULAR, USCELL, VIRGIN

Patient Name: _____ Social Security Number: _____

Home Address: _____ City: _____ State: _____ Zip: _____

Email Address:_____(P/B) Sex: F or M Age: _____ Date of Birth: _____

Circle One: Single / Divorced / Widowed / Minor / Married / Separated / Partnered

Patient Employer/School: _____ Occupation: _____

Employer/ School Address: _____ Employer/ School Phone: (_____) _____

In case of Emergency, who should be notified? _____ Phone: (_____) _____

Were you referred to our Office? Y / N If so, by whom? _____

Full Name of Primary Insured: _____ Relationship: _____

If Other then Patient: Date of Birth: _____ Social Security Number: _____

Employer: _____ Name of Insurance Company: _____

Subscriber ID: _____Group #:_____

Secondary Insurance

Full Name of Primary Insured: _____ Relationship: _____

Date of Birth: _____ Social Security Number: _____ Employer: _____

Name of Insurance Company: _____ Subscriber ID:_____

I certify that I, and/or my dependent(s) have insurance coverage with _____ and authorize payment to Clough Chiropractic, Inc. DBA Marcon Chiropractic & Wellness Center, all benefits. If any, otherwise payable to me for services rendered, I understand that I am financially responsible for all charges whether paid by insurance, and for all services rendered on my behalf or my dependents. The above named corporation may use my health care information and may disclose such information to the above named insurance company (ies) and their agents for the purpose of obtaining payment for services and determining Insurance benefits or the benefits payable for related services. I authorize the use of my signature on all Insurance submissions. This consent will end when my current treatment plan is completed or one year from the date signed below.

_____ _____

Signature of Patient, Guardian or Person Responsible Date

_____ _____

Please print name of Patient, Guardian or Person Responsible Relationship to Patient

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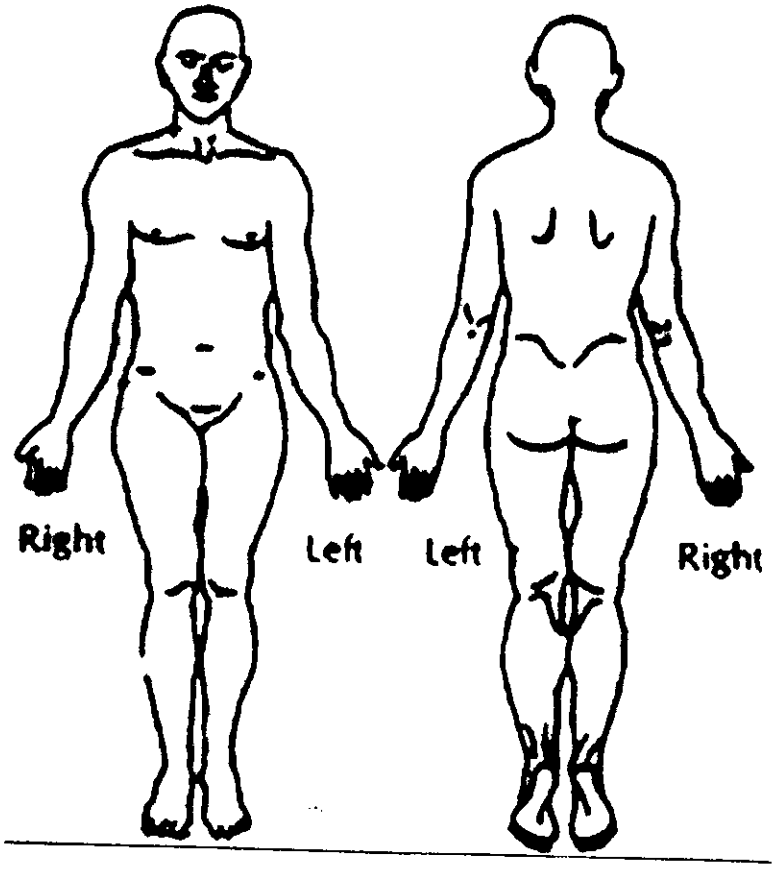
Patient Name:_____ Date: _____

PLEASE PLACE AN "X" OVER THE AREA(S) WHERE YOU EXPERIENCE PAIN OR DISCOMFORT



PLEASE CHECK ANY OF THE FOLLOWING THAT APPLY TO YOU:

____Any Recent Weight Gain/Loss
____Weakness
____Fatigue
____Fever
____Fainting Spells
____Nausea
____Vomiting
____Balance Problems
____Jaw Pain (TMJ)
____Neck Pain
____Neck Stiffness
____Shoulder Pain
____Arm Pain
____Wrist/Hand Pain
____Numbness Arms or Hand

____ Upper Back Pain
____ Lower Back Pain
____ Hip Pain
____ Leg Pain
____ Ankle/Foot Pain
____ Numbness Legs or Feet
____ Joint Swelling
____ Tension
____ Nervousness
____ Anxiety
____ Irritability
____ Sleeping Problems/Insomnia
____ Depression
____ Liver Problems
____ Cancer (If yes indicate when & Type)
_____

____Metal Implant (If yes indicate when & where)
____ Headaches
____ Loss of Consciousness
____Dizziness
____ Memory Loss
____Seizures/Convulsions
____ Double Vision
____ Blurred Vision
____Loss of Vision
____Eyes Sensitive to Light
____Loss of Hearing
____Ringing/Buzzing in Ears (Tinnitus)
____ Ear Infections
____Vertigo
____Any discharge from Ears

Continue on Next Page

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NOSE
____Sinus Problems
____Nose bleeds
____Loss of Smell
____Any Discharge from Nose

MOUTH/THROAT
____ Tooth Pain
____ Any Lesions/sores in mouth/lips/gums
____Frequent Sore Throats
____ Difficulty Swallowing
____Thyroid Problems

RESPIRATORY (LUNG PROBLEMS)
____Difficulty breathing ____ Emphysema
____ Chronic Cough ____History of TB or Pneumonia
____ Asthma ____ Date of Last Chest X-ray
____Bronchitis

CARDIOVASCULAR (HEART PROBLEMS)
____Chest Pain ____ High Blood Pressure
____Shortness of Breath ____ Low Blood Pressure
____Palpitations ____Heart Murmur
____Night Sweats ____ Ever have an ECG/EKG
____Cold Extremities

GASTROINTESTINAL
____Upset Stomach ____Diarrhea/Lose Stools
____ Loss of Appetite ____Bloody Stools
____ Indigestion ____ Abdominal Pain
____Constipation ____Excessive gas
____Loss of Bowel Control

GENITAL/URINARY (FEMALES)
____History of Pelvic Inflammatory
____Urinary Tract Infections
____Breast Cancer/Cyst Formation
____Blood in Urine
____Vaginal Discharge
____PMS
____ Loss of Bladder Control
____ Currently Pregnant
____ Use Birth Control Pills
____Date of Last Menstruation
____ Menopause- Age: ____
____ Last Pelvic Exam: (Date & Results) _____
_____
Last OB/GYN Exam
____ Any Sexual Transmitted Diseases (STD's

GENITAL/URINARY (MALES)
____Prostate Problems
____Hernia
____Penile Discharge
____Blood in Urine
____ Painful Urination
____ Frequent Urination
____Testicular Pain
____ Loss of Bladder Control
____Last Prostate Exam: _____
____ Last PSA Test: _____
____ Any Sexual Transmitted Diseases (STD's)

ENDOCRINE:
____Cold or Heat Intolerance
____Excessive Sweating
____Excessive Thirst or Hunger
____ Diabetes Type I
____ Thyroid Problems
____ Kidney Problems
____ Diabetes Type II
Insulin Y or N

MEDICATIONS:

SOCIAL HISTORY:
____Tobacco Use ____ Alcohol Use

_____
Patient Signature

_____
Date

All healthy relationships are built on mutual trust and respect. I, as the Doctor, will make every effort to stay on schedule and give you the time and attention you need. In return I ask that you the patient to:

1. Arrive on time for scheduled appointments.
2. Dress appropriate for Treatment. The area of chief complaint should be easily accessible. ***We do have disposable shorts for special circumstances.***
3. Call us when you are running late or unable to keep the appointment.
4. If you are unable to make a scheduled appointment we ask that you notify the office no later than 12 hours in advance of the appointment. Each patient is afforded the courtesy of a single missed/non-canceled appointment-Everyone forgets occasionally. If you miss a second scheduled appointment without proper notification, you will **not** be assessed a fee but we will not reschedule you for treatment until you meet with someone from our office to explain your circumstances. If we all are in agreement that you will be able to manage appointments moving forward we can resume scheduling.

No amount of "Missed Appointment" fees can recoup time and despite the power of Chiropractic Care, it doesn't work if you don't show up.

5. If you have a complaint or concerns TELL US. If you like the way you feel TELL OTHERS. Both are indispensable to our success.

David J. Marcon, DC

"Doc"

_____

Patient Name/Date