

PATIENT PERSONAL/CONFIDENTIAL DATA

No. _____ Date _____

Patient: _____ Date of Birth: _____

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

Social Security No.: _____ Home Phone: _____ Work Phone: _____

Employer: _____ Address: _____

Name of Spouse _____ SS No.: _____ No. of Children: _____

Spouse's Employer: _____ Address: _____

How did you learn of this clinic? _____

Nearest relative not living with you? _____ Phone: _____

Who is responsible for payment? ☐ Self ☐ Spouse ☐ Other _____

PATIENT'S INSURANCE

SPOUSE'S INSURANCE

Name of Company: _____ Name of Company: _____

Address: _____ Address: _____

ID & Group No.: _____ ID & Group No.: _____

Phone No.: _____ Phone No.: _____

Purpose of this appointment and list your complaints: _____

Date of illness: _____ Time: _____ ☐ AM ☐ PM Location: _____

How did accident occur? ☐ Auto ☐ On the job ☐ Other, _____

Please describe the circumstances and what makes the condition(s) better or worse: _____

Other Doctor seen for this condition: _____

Have you been treated by a Doctor for any health condition in the last year? ☐ Yes ☐ No

If yes, please describe: _____

INSURANCE INFORMATION

I understand and agree that health and accident insurance policies are an agreement between an insurance carrier and myself. Furthermore, I understand that this Chiropractic 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 this Chiropractic Office will be credited to my account upon receipt. 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. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered to me will be immediately due and payable.

Signature Physician: _____ Signature Patient: _____

CONSENT OF PROFESSIONAL SERVICES AND RELEASE OF INFORMATION

I hereby authorize and release the doctor and whom ever he/she may designate as his/her assistants to administer treatment, physical examination, X-Ray studies, laboratory procedures, chiropractic care or any clinic services that he/she deems necessary in my case; and I further authorize him/her to disclose all or any part of my (patient's) record to any person or corporation which is or may be liable under a contract to the clinic or to the patient or to a family member or employer of the patient for all or part of the clinic's charge, including, and not limited to, hospital or medical services companies, insurance companies, workers compensation carriers, welfare funds, or the patient's employer.

Patient's Signature: _____

Parent's or Guardian's Signature: _____