Patient Personal/Confidential Data

Date___________________________

Patient: ____ Date of Birth: ___________________

Home Address: ______________________________ City: _______________ State: ________ Zip: __________

Social Security No: _____________________________ Home Phone: __________________________________

E-mail Address: _________________________________ **Cell Phone**: __________________________________

Employer / Occupation: _________________________________ Work Phone: ___________________________

Name of Spouse: ____________________________ Employer / Occupation: _____________________________

Names /Ages of Children:

1. Name: ________________ Age: _____________
2. Name: ________________ Age: _____________
3. Name: ________________ Age: _____________
4. Name: ________________ Age: _____________

Who referred you to our clinic? ____

Who is responsible for payment? Self Spouse Other____

List all current medications: ____

____

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

If yes, please describe: ____

____

Type of Insurance ____

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.

Patient Signature: ____ Date: ________________________

CONSENT FOR PROFESSIONAL SERVICES AND RELEASE OF INFORMATION

I hereby authorize and release the doctor and whomever 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 Signature: ____Date: ________________________

Parent's or Guardian's Signature: ____ Date: ________________________

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