

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: _____

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: _____