PATIENT PERSONAL/CONFIDENTIAL DATA

Patient _____ Date of Birth _____ Date: _____

Home Address _____ City _____ State _____ Zip _____

Social Security No _____ Home Phone _____ Work Phone _____

Employer _____ Address _____

Name of Spouse _____ No of Children ____ E-mail _____

Spouse's Employer _____ Address _____

How did you learn of this clinic? _____

Nearest relative not living with you? _____

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

PATIENTS INSURANCE

Name of Company _____

Address _____

ID & Group No _____

Phone No _____

SPOUSE'S INSURANCE

Name of Company _____

Address _____

ID & Group No _____

Phone No _____

State the 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 _____

_____

_____

_____

Please list the other doctors you have 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 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 any fees for the professional services rendered to me will be immediately due and payable.

Physician Signature _____ Patient Signature _____

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 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 service companies, insurance companies, workers compensation carriers, welfare funds, or the patient's employer

Patient Signature _____

Parent or Guardian Signature _____