Patients Personal/Confidential Data

No. ______________________ Date:_____________________

Patient: ____ Date of Birth:______________

Home Address: __________________________City:___________ State: ____ Zip: ___________________

Social Security No.: ____________________________Home Phone:_____________________________

Cell Phone: __________________________________ Email: _______________________________________

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 of payment? □ Self □ Spouse □ Other_________________________________

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 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:____________________________ Patient Signature:____________________________

CONSENT OF PROFESSIONAL SERVICES AND RELEASE OF INFORMATION

I hereby authorize and release the doctor and whomever he may designate as his assistant to administer treatment, physical examination, X-Ray studies, laboratory procedures, chiropractic care or to the 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 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:__________________________

Patient's or Guardian's Signature:__________________________