

PATIENT CONFIDENTIALITY PERSONAL DATA

No. _____ Date _____
Patient: _____ Date of Birth: _____
Home Address: _____ City: _____ State: _____ Zip: _____
Social Security No.: _____ Home Phone: _____ Mobile: _____
Work 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 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 on 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 the doctor and whomever he may designate as his assistants to administer treatment, physical examination, X-Ray studies, laboratory procedures, chiropractic care or any clinic services that he/she deems necessary in any 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: _____