

Confidential Patient Information

Name _____ Date _____

E-mail Address _____ Phone # _____ Cell # _____

Address _____

City _____ State _____ Zip _____

Age _____ Birth Date _____ Marital Status: M S W D # of Children? _____

Occupation _____ Employer _____

Address _____ Office Phone _____

Student at _____ Full Time ___ Part Time ___

Name of Spouse _____ Occupation _____

Employer _____ Address _____

Name of Nearest Relative _____

Address _____ Phone _____

Name of Insurance Company _____

Group # _____ ID # _____

Provider Services Phone number _____

Purpose of this appointment _____

Other doctor seen for this condition _____ Ph. # _____

Have you been treated for any health condition by a physician in the last year? YES NO

Describe _____

What medications or drugs are you taking? _____

Primary Care Physician _____ Ph. # _____

I understand and agree that health and accident insurance policies are an arrangement between my insurance company and myself – not between my insurance company and this office. I authorize this chiropractic clinic to release any medical information and to complete any usual and customary reports and forms at no charge to assist in collecting from my insurance company.

If mine is a regular health insurance case, I agree to pay a percentage of services as they are rendered. However, I understand that I am ultimately responsible for payment in full at this office. I also understand that if I suspend or terminate my schedule of care as determined by my treating doctor, any fees for professional services will be immediately due and payable. If payment is not received after 30 days of receiving bill interest will accrue at 18 percent per annum.

Patient's Signature _____ Date _____

Guardian's Signature Authorizing Care _____ Date _____