Chiropractic Patient Information

Date _____

Name _____ Social Security # _____

Address _____ City _____ State _____ Zip _____

Home Phone _____ Cell Phone _____

E-mail address: _____ Sex M F

Age _____ Birth Date _____ Marital: M S W D How many children? _____

Occupation _____ Employer _____

Employer's Address _____ Work Phone _____

Spouse _____ Occupation _____ Employer _____

If you are under the age of 18, what are your parents' names? _____

How were you referred to our office? _____

Family Medical Doctor _____

Purpose of this appointment _____

Date symptoms appeared or accident happened _____

Have you ever had the same or a similar condition? □ Yes □ No

Days lost from work _____

Date of last physical examination _____ What surgeries have you had? (Include dates)

_____

Serious illnesses (include dates) _____

_____

Have you been treated for any health condition by a physician in the last year? □ Yes □ No

If yes, describe: _____

What medications or drugs are you taking? _____

_____

Please check any and all insurance coverage that may be applicable in this case.

□ Major Medical □ Worker's Compensation □ Medicaid □ Medicare □ Auto Accident □ Other

Name of Primary Insurance Company _____

Name of Secondary Insurance Company (if any) _____

AUTHORIZATION AND RELEASE: I authorize payment of insurance benefits directly to the chiropractor or chiropractic office. I authorize the doctor to release all information necessary to communicate with personal physicians and other healthcare providers and payers and to secure the payment of benefits. I understand that I am responsible for all costs of chiropractic care, regardless of insurance coverage. 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. All accounts not paid in 90 days may be subject to collection actions. I understand that interest is charged on overdue accounts at the annual rate of 18% compounded monthly.

The patient understands and agrees to allow this chiropractic office to use their Patient Health Information for the purpose of treatment, payment, healthcare operations, and coordination of care. We want you to know how your Patient Health Information is going to be used in this office and your rights concerning those records. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your Patient Health Information we encourage you to read the HIPAA NOTICE that is available to you at the front desk before signing this consent. If there is anyone you do not want to receive your medical records, please inform our office.

Patient's Signature _____ Date _____

Guardian's Signature Authorizing Care _____ Date _____