Chiropractic History/ Patient Information

Name: _____Social Security #: _____

Address:_____City: _____

State: _____Zip code: _____

Home Phone #: _____ Cell Phone #: _____

E-mail : _____

Age: _____Birth Date : _____Marital: S M D W

Occupation: _____ Employer: _____

Employer's Address _____Work Phone #: _____

Spouse: _____ Occupation: _____Employer: _____

Name and Age of Children: _____

_____

Nearest Relative: _____Phone #: _____

Address : _____

How were you referred to our office? _____

Family Medical Doctor: _____

When doctors work together it benefits you. May we have your permission to update your medical doctor regarding your care at this office: Yes or No

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 payors 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.

The patient understands and agrees to allow this chiropractic office to use their Patient Helath 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 HIPPA NOTICE that is available to you at the front desk before signing this consent.

Patient's Signature : _____Date : _____

Guardian's Signature: _____Date: _____

(Authorizing care)