## PATIENT INFORMATION

Legal First Name_____ MI____ Last Name_____
Street_____ Apt #_____
City_____ State_____ Zip_____

Social Security #:_____ Marital Status: S M W D Spouse_____

Names and Ages of Children:_____

Language: [ ] English [ ] Spanish [ ] Indian [ ] Japanese [ ] Chinese [ ] Korean [ ] French [ ] German [ ] Russian [ ] Other_____

Race: [ ] White [ ] Black or African American [ ] Hispanic or Latino [ ] American Indian or Alaska Native [ ] Native Hawaiian/Other Pacific Islander

[ ] Asian [ ] Decline to Answer [ ] Other_____ Ethnicity: [ ] Hispanic or Latino [ ] Not Hispanic or Latino [ ] Decline to Answer

DOB:_____/_____/_____ Home Phone:_____ Work Phone:_____

Cell Phone:_____ Cell Carrier:_____

Please check you contact preference: [ ] Home [ ] Work [ ] Cell [ ] Email [ ] US Mail

Email Home_____ Email Work_____

Occupation:_____ Employer:_____

Employer Address:_____

Emergency Contact:_____ Phone #:_____

## GUARDIAN/PARENT NAME IF PATIENT IS A MINOR

Legal First Name_____ MI_____ Last Name_____
Street_____ Apt #_____
City_____ State_____ Zip_____
DOB:_____/_____/_____ Social Security #_____

Home Phone:_____ Work Phone:_____Cell Phone:_____

## HEALTH INSURANCE INFORMATION

*We will make a copy of your insurance car/s. However, please complete the following information if you are not the policyholder.*

### [ ] I do not have health insurance

Are you the policy holder? Yes No If no, how is this person related to you? Spouse Parent Other

Policy Holder's First Name:_____ MI:_____ Last Name:_____

Policy Holder's DOB:_____/_____/_____ Policy Holder's SSN:_____

Insurance Company:_____ Member ID:_____

Do you have secondary Insurance Coverage? Y N If yes, complete the following:

Policy Holder's First Name:_____ MI:_____ Last Name:_____

Policy Holder's DOB:_____/_____/_____ Policy Holder's SSN:_____

Insurance Company:_____ Member ID:_____

# ASSIGNMENT AND RELEASE

**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 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 doctor's 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 and that I am personally responsible for payment. In the event it becomes necessary for this office or its agents to employ legal and/or collection counsel, I understand and agree I am responsible for payment of all collection charges, legal fees, interest fees and court costs.**

**X**_____ _____

**Patient Signature or person acting on patient's behalf** **Date**

**CONSENT OF PROFESSIONAL SERVICES AND RELEASE OF INFORMATION**

I hereby authorize and release the doctor and whomever he/she may designate as his/her assistants, to administer treatment, physical examination, x-ray studies, chiropractic care or any clinic services that he/she deems necessary in my case; I furthermore authorize him/her to disclose all or any part of my patient record to any person or corporation which is or may be liable under a contract to this office 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 service companies, insurance companies, workers' compensation carriers, welfare funds, or the patient's employer

**X**_____ _____

**Patient Signature or person acting on patient's behalf** **Date**

# HIPPA PRIVACY STATEMENT

By subscribing my name and signature below, I acknowledge that I have the opportunity to receive a current copy of HIPPA guidelines and am in agreement to, and understand with, its terms and conditions.

In the event I am unable to pick up records, x-rays or am unable to communicate with this office, I allow the following person(s) to make contact with this office and speak on my behalf.

Name_____ DOB:_____ Relationship_____
Name_____ DOB:_____ Relationship_____

**Signature:X**_____ **Date**_____

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## Please answer the following questions:

Have you ever been to a chiropractor before? [ ] No [ ] Yes, Who_____When_____

Have you ever been in an auto accident? [ ] No [ ] Yes, When_____

Have you ever been injured at work? [ ] No [ ] Yes, When_____

How did you hear about us? [ ] Yellow Pages [ ] Sign [ ] Internet [ ] Referral from another doctor, Who_____
[ ] Attorney, Who _____ [ ] Patient, Who_____

**THANK YOU FOR CHOOSING US TO SERVE YOUR CHIROPRACTIC NEEDS**