

ACTIVE CARE
CHIROPRACTIC
ALIGNMENT • NUTRITION • MOVEMENT

PATIENT INFORMATION

LAST NAME_____FIRST_____ M.I. _____

BIRTHDATE_____ AGE _____ SOCIAL SECURITY # _____-_____-_____

ADDRESS _____CITY _____ST _____ ZIP_____

CELL PHONE _____ HOME _____ _

EMAIL ADDRESS _____

SPOUSE _____ CHILDREN (Name/Age) 1._____ 2._____ 3._____

WHO REFERRED YOU TO OUR OFFICE?_____

EMPLOYMENT INFORMATION

OCCUPATION _____ WORK PHONE _____

HEALTH HISTORY

PAST CHIROPRACTIC CARE (Circle One) YES NO _____

DATE OF LAST VISIT _____ CHIROPRACTOR NAME _____

REASON FOR CONSULTING THIS OFFICE? _____

PAYMENT & INSURANCE INFORMATION

WHO IS RESPONSIBLE FOR THIS ACCOUNT _____

RELATIONSHIP TO PATIENT _____ PHONE _____

WILL YOU BE USING INSURANCE? YES NO INSURANCE COMPANY NAME _____

ASSIGNMENT AND RELEASE FOR INSURANCE

I certify that I (and my dependents) have insurance coverage with the above company and assign directly to Kristof Szentivanyi, D.C., Active Care Chiropractic, all insurance benefits, if any, payable for services rendered. I understand that I am fully financially responsible for charges that my insurance company will not cover if they say that an office visit, procedure or treatment is "not medically necessary", "preexisting", "deductible", or other related reason for non-payment. I also understand that what my carrier considers "non-medically necessary", may, on the contrary, be considered medically necessary by this office and its doctor. Therefore, I agree to hold Kristof Szentivanyi, Active Care Chiropractic harmless for any medical decisions made by my insurance/managed care carrier which may in any way compromise my best care and result in medical damage, loss or death. I authorize to release pertinent medical information to my insurance company when requested to or to facilitate payment of a claim. Your signature at the end of this document acknowledges you understand this and authorize this office to submit and collect from insurance for services rendered.

INITIAL YOU HAVE READ THE ABOVE:_____

WE ACCEPT PAYMENT BY CASH, CHECK, AND CREDIT CARD

I understand that all services are to be paid in full at the time of service, unless other arrangements have been made and agreed upon in writing.

SIGNATURE:_____ **DATE:**_____