Welcome to our practice!

Please Read Before Printing

Adult Patients: Print Pages 2-8

Pediatric Patients (0-14 years old): Print Pages 9-14

Personal Injury/Auto Accident Patients: Print Pages 15-30

PATIENT INFORMATION

Name: ______________________________ Date of Birth: ____________ Social Security #: _____-___-____

Address:__________________________________ Marital Status: S M W D Race:________________

__________________________________ Email Address: ________________________

Home Phone: ______________________ Cell Phone: __________________ Cell Carrier: ______________

Work Phone: ______________________ Extension: __________

Occupation: _________________________ Employer: ____

Spouse: _______________________ How many children? ____ Names and ages: _____________________

Name of nearest relative: ____________________________ _____________________

Address: __________________________________ Phone Number: ______________________________

____

Family Medical Doctor: ________________________ Phone Number: ____________________________

When doctors work together it benefits you. May we have your permission to update your medical doctor regarding your care at this office? Y N

How were you referred to our office? ____

By signing below, you acknowledge that periodic communications sent by HCW via text message, phone, and email, could potentially cause additional charges for you under your cell phone or other data plan. In the event that you do not want to receive such periodic communications, please notify us in writing of your desire to be removed from such communications.

****

INSURANCE

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

( ) Major Medical ( ) Medicare ( ) Auto Accident ( ) Worker's Comp. ( ) Medical Savings/Flex Plan

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.

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 your rights concerning the privacy of your Patient Health Information we encourage you to read the HIPPA NOTICE that is available to you before signing this consent. The following person(s) have my permission to receive my personal health information: ________________________

____

Patient/Guardian Signature: ______________________________________ Date: ____________________

For Office Use Only: Treatment Plan: 4/4/4 3/3/3 Other: ________

Adjustment: Right Upper D A Left Upper D A Mech Trac Flex/Dist Div C T L Activator C T L Man Ther US EMS Ice Heat Vib

Comp Fx___ Lat. Curve______ Tilt______ List______ Listhesis______ Disc Ht______ Ostephyte______ Scoliosis______

Sublux__________ Low Pelvis____Trans Seg____ Fx/Path____ Other____