ALLIANCE CHIROPRACTIC CENTER
AND ACUPUNCTURE

Name: ____ Date: ____________________________________

Address: ____ City, State, Zip: ______________________________

Phone: ____ Cell: ____

Email: ____

Age: ___________ Birthdate: ___________________________ Gender: ______________

Race: ____ Ethnicity: ____

Occupation: ____ Employer: ____

Spouse: ____ Spouse phone: ____

Insurance Name and Phone number (ignore if you have provided the card):

____

Insurance ID: ____ Group: ____________________________________

Assignment and Release

I, the undersigned, certify that I (or my dependent) have insurance coverage with ____ and assign directly to Dr. Wente-Moeller and Alliance Chiropractic Center all the insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Signed: ____ Date: ____

Relationship to Patient: ____

I understand that Alliance Chiropractic Center is not liable for differences between what the insurance company quotes and what they actually pay and that I am ultimately responsible for knowing the benefits I am eligible for. Initial: ____________________

Emergency Contact (name and number): ____

Persons with whom you may share my information: ____

Is this Accident Related: Yes No If Yes, who is responsible for payment? ____

Do you have an Attorney? Name and number: ____

Whom May We Thank for Referring You? ____

Primary Care/ Referring Doctor: ____

Do you want a report sent? Yes No

Facilities that have records or X-Rays pertaining to this issue: ____

Current Health Issues: ____

Are you pregnant? Yes, Due date: ________________ No Not Sure Do you smoke? How much? ____________________

Medications: ____

Allergies: ____

Surgical History: ____

Past Fractures or Serious Injuries/Accidents: ____

Please CIRCLE any of the following if you HAVE NOW or HAVE EVER had them:

AIDS/HIV	Diabetes	Kidney Disease	Psychiatric Care
Alcoholism	Eating Disorder	Liver Disease	Rheumatoid Arthritis
Allergy Shots	Emphysema	Measles	Scoliosis
Anemia	Fractures	Migraine	Sexually Transmitted Disease
Appendicitis	Glaucoma	Miscarriage	Stroke
Arthritis	Goiter	Mononucleosis	Suicide Attempt
Bleeding Disorders	Gout	Mumps	Thyroid Problems
Breast Lump	Heart Disease	Osteoporosis	Tuberculosis
Bronchitis	Hepatitis	Pacemaker	Tumors, Growths
Cancer	Hernia	Parkinson's	Ulcers
Cataracts	Disc Problems	Pneumonia	Vaginal infection
Chemical Dependency	High Cholesterol	Prostate Problems	Other: ____________________
Chicken Pox	Hypertension	Prosthesis	_________________________

Terms of Acceptance: The goal of our office is to enable patients to gain control of their health. To attain this, we believe communication is the key. There are often topics that are hard to understand, and we hope this document will clarify those issues for you. Please read and Sign.

Informed Consent:

A patient, in coming to a chiropractic doctor, gives the doctor permission and authority to care for the patient in accordance with the chiropractic tests, diagnosis and analysis. The chiropractic adjustment or other clinical procedures are usually beneficial and seldom cause any problems. In rare cases, underlying physical defects, deformities or pathologies may render the patient susceptible to injury. The doctor will not give any treatment or care if she is aware that any such care will be contra-indicated. It is the responsibility of the patient to make it known, or to learn through healthcare procedures what he/she is suffering from: latent pathological defects, illness or deformities which would otherwise not come to the attention of the chiropractic physician through normal testing methods. The chiropractic doctor provides a specialized, non-duplicating health care service. Your Doctor of Chiropractic is licensed in a specialized practice and is available to work with other types of providers in your health care regimen. I understand that if I am accepted as a patient by Dr. Wente-Moeller, I am authorizing her to proceed with any treatment that she deems necessary. Furthermore, any risk involved, regarding specific treatments, will be explained to me upon my request.

Signature: ____ Date: __________________________