NORTHWOOD SPORTS MEDICINE&
PHYSICAL REHABILITATION, INC
2790 N. MILITARY TRAIL, WPB,FL
561-478-7555

ANDERSON CHIROPRACTIC CLINIC
2790 N. MILITARY TRAIL
WEST PALM BEACH, FL 33409
561-683-4971

PATIENT INFORMATION

(Please complete as thoroughly as possible)

Date: _____

PATIENT NAME: _____
First MI Last

ADDRESS: _____ **DATE OF BIRTH:** _____

CITY: _____ **STATE:** _____ **ZIP:** _____

PHONE: (HOME) _____ **CELL** _____ **WORK** _____

E-MAIL ADDRESS _____

SOCIAL SECURITY NO: _____ **SEX** ___**MALE** ___**FEMALE**

MARITAL STATUS ____ **SINGLE** ___**MARRIED** ___ **DIVORCED** ___**WIDOWED**

DRIVERS LICENSE # _____ **STATE ISSUED** _____
(PLEASE PROVIDE THIS OFFICE WITH YOUR DRIVERS LICENSE TO BE COPIED FOR YOUR FILE)

EMPLOYER : _____

ADDRESS: _____ **CITY:** _____

STATE: _____ **ZIP:** _____ **OCCUPATION:** _____

FULL TIME: _____ **PART TIME** _____ **RETIRED** _____ **NOT EMPLOYED** _____

IF A STUDENT, ARE YOU **FULL TIME** _____ **OR** **PART TIME** _____

IS THERE INSURANCE INVOLVED FOR THIS VISIT? _____YES _____NO
(If there is no insurance, how will you pay for todays visit?) _____
(PLEASE PROVIDE WITH ANY AND ALL INSURANCE CARDS TO COPY)

INSURANCE INFORMATION:

Insurance Company: _____

Address _____ City_____

State _____ Zip _____ Phone Number _____

Insured's Name_____ Insured's Date of Birth _____ Policy#_____

Claim# _____ Group#_____ Employer _____Adjuster_____

Is this related to an: (Auto Accident ___) (Workers Comp __) (Slip & Fall ___)

or (Other ____) Date of Accident _____ Place/State of Accident_____

Is there an attorney involved? ____Yes ___No. If so please give name and phone.

Number:_____

Please describe your current complaints_____

_____

When did this first start with these complaints?_____

What do you think caused this problem?_____

The above information is true and accurate:_____
(Patient Signature)

RELEASE OF INFORMATION

I hereby authorize **NORTHWOOD SPORTS MEDICINE AND PHYSICAL REHABILITATION, INC.** to: furnish my insurance company or companies and the patient's attorney with any and all information that may be contained in my medical records; to obtain coverage information telephonically from my insurer; to request a written non-redacted PIP payout sheet from the insurer; and to obtain copies of my medical records, including but not limited to, documents, reports, scans, notes, opinions, X-rays, and MRI's received from any other medical provider or any insurance company. The insurer is directed to keep the patient's medical records private and confidential. The insurer is **NOT** authorized to provide these medical records to anyone, including but not limited to, third party vendors without the patient's and the provider's prior express written permission.
The undersigned does hereby ratify and confirm and all actions taken by the said attorney in accordance with this special power and which the said attorney shall do or cause to be done by virtue of these presents.

_____ Date _____ _____
Patient Signature **Patient Please Print Name**