NEW PATIENT INFORMATION

NAME _____ HOME PHONE _____ DATE _____

MOBILE PHONE _____ EMAIL ADDRESS _____

ADDRESS _____ CITY _____ ST ____ ZIP _____

AGE ____ BIRTHDATE _____ SOCIAL SECURITY NUMBER _____

OCCUPATION _____ EMPLOYER _____ WORK PHONE _____

MARRIAGE STATUS M S W D NUMBER OF CHILDREN & AGES _____

SPOUSE'S NAME _____ EMPLOYER _____ WORK PHONE _____

EMERGENCY CONTACT _____ PHONE _____ RELATION _____

FAMILY PHYSICIAN _____ PHONE _____ LAST SEEN _____

REFERRING PHYSICIAN _____ PHONE _____ LAST SEEN _____

WHOM MAY WE THANK FOR REFERRING YOU TO US? _____

Welcome to our office. Our doctor is always willing to help you, your family & friends. Our practice grows from referrals, and we appreciate the people you send to our office. Our office is recognized for quality service and dedication to our patients. We welcome children in our office. We accept cases based on examination findings and diagnostic tests. There are no guarantees or promises of improvement or complete recovery.

Many insurance plans cover chiropractic services. All plans are different. Medicare claims will be sent in from this office; however, we do not accept assignment.

Payment is due when services are rendered for all costs. Although we accept assignment on work injury and auto accident claims, you are fully responsible for all costs. As a courtesy to you, if it is necessary to allow for processing of accident/injury case settlements, we may grant you up to 90 days for full payment on your account. Balances from auto, work and personal injury claims must be paid in full within 90 days of release from treatment. Service charges of 1.5% per month - 18% per annum are added to all balances outstanding 60+ days and are the responsibility of the patient. Any account past 90 days is subject to legal collection.

By my signature below, I clearly understand and agree that all services rendered to me are charged directly to me, and I am personally and fully responsible for payment.

Your signaute below also fully authorizes our dostor to perform any examinations, diagnostic tests, and/or treatment as he considers medically necessary and to release such information to applicable parties on your behalf.

I hereby request and consent to chiropractic manipulation and other procedures which may include various modes of physiotherapy and diagnostic tests by this office. I have had an opportunity to discuss with the doctor and/or his office personnel the nature and purpose of treatment indicated. I understand that results are not guaranteed and am informed that, as in the practice of medicine, in the practice of chirpractic there are some risks to treatment, including but not limited to: fractures, disc injuries, strokes, dislocations and sprains. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely on the doctor to exercise judgement during the course of any procedure which he feels at the time is in my best interest. I have read, or have had read to me the above consent and have also had an opportunity to ask questions about its content and by signing below I agree to the above terme and procedures. I intend this consent to cover any treatment for my present condition and for any future condition(s) for which I seek treatment here.

SIGNATURE _____ DATE _____