

ABOUT THE PATIENT

Name _____ Gender ____ M ____ F Age _____

Address _____ City _____ State ____ Zip _____

Home Phone _____ Birthdate _____ Number of children _____

Marital Status Married ____ Single ____ Divorced ____ Separated ____ Widowed ____

Employer _____ Work Phone _____

Social Security # _____ Driver's License # _____

Email Address _____ Cell Phone Number _____

EXPERIENCE WITH CHIROPRACTIC

Who referred you to this office? _____

Have you been adjusted by a Chiropractor before? Yes _____ No _____

Reason for those visits? _____

Doctor's Name _____ Approximate Date of Last Visit _____

Has any *adult* in your family seen a Chiropractor? Yes _____ No _____

Has any *child* in your family seen a Chiropractor? Yes _____ No _____

OWNERSHIP OF X-RAYS

It is understood and agreed that the payments to the Doctor for x-rays is for examination of x-rays only. The x-ray negatives will remain the property of this office. They are kept on file where they may be seen at any time while I am a patient of this office.

AUTHORIZATION FOR CARE

I hereby authorize the Doctor to work with my condition through the use of adjustments to my spine, as he deems appropriate.

I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I agree that I am responsible for all bills incurred at this office. The Doctor will not be held responsible for any pre-existing medically diagnosed conditions nor for any medical diagnosis. I also understand that if I suspend or terminate my care, any fees for professional services rendered me will become immediately due and payable. I hereby authorize assignment of my insurance rights and benefits (if applicable) directly to the provider for services rendered.

Patient's signature

Date

Parent/guardian Signature Authorizing Care

Date