

Chiropractic Health Associates

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<p>Patient Information</p> <p>Date _____ SS# _____</p> <p>Patient Name _____ Last Name</p> <hr/> <p>First Name _____ Middle _____ Name</p> <p>Address _____</p> <p>City _____ State _____</p> <p>Zip _____ Email _____</p> <p>Sex <input type="checkbox"/> M <input type="checkbox"/> F DOB _____ Age _____</p> <p><input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Single <input type="checkbox"/> Minor <input type="checkbox"/> Separated <input type="checkbox"/> Divorced</p> <p>Occupation _____</p> <p>Patient Employer/School _____</p> <p>Employer/School Address _____</p> <hr/> <p>Employer/School Phone _____</p> <p>Spouse's Name _____</p> <p>DOB _____ SS# _____</p> <p>Spouse's Employer _____</p> <p>Phone Numbers</p> <p>Home# (____) _____</p> <p>Cell# (____) _____</p> <p>Best time to reach you _____</p> <p>In case of emergency, contact:</p> <p>Name _____ Relationship _____</p> <p>Home# (____) _____ Work# (____) _____</p>	<p>Insurance</p> <p>Who is responsible for account? _____</p> <p>Insurance Co _____</p> <p>ID # _____ Group # _____</p> <p>Subscriber's Name _____</p> <p>DOB _____ SS# _____</p> <p>Relationship to Patient _____</p> <p>Assignment and Release</p> <p>I certify that I, and/or my dependent(s), have insurance coverage with _____ and assign directly to Chiropractic Health Associates all 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 authorize the use of my signature on all insurance submissions. The above named clinic may use my health care information and may disclose such information to the above-named insurance company and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.</p> <p>_____ Signature of Patient, Parent or Guardian</p> <p>_____ Print Name of Patient, Parent or Guardian</p> <p>_____ Date _____ Relationship to Patient _____</p> <p>Accident Information</p> <p>Is condition due to an accident? <input type="checkbox"/> Yes <input type="checkbox"/> No Date _____</p> <p>Type of accident <input type="checkbox"/> Auto <input type="checkbox"/> Work <input type="checkbox"/> Home <input type="checkbox"/> Other</p> <p>To whom have you reported your accident? <input type="checkbox"/> Auto Insurance <input type="checkbox"/> Employer <input type="checkbox"/> Work Comp <input type="checkbox"/> Other</p> <p>Attorney Name (if applicable) _____</p>
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I hereby authorize the Doctor to treat my condition as he deems appropriate through the use of treatment methods used. If female, I attest that I am currently not pregnant and that it is okay to take any necessary x-rays. I also agree that I am responsible for all bills incurred in this office. I understand that the Doctor will provide care with the intent to remove energy blockages and if unable to achieve the level of care desired through treatment methods offered will refer me to and healthcare professional.

Patient's Signature _____ Date _____

Parent or Guardian Signature _____ Date _____

