CONFIDENTIAL PATIENT INFORMATION

Please Print Date _____/_____/_____

PATIENT INFORMATION

Full Name: _____ Date of Birth: _____/_____/_____ Age: _____ ☐ Male ☐ Female

Address: _____ Apt#: _____ SSN: _____-_____-_____

City: _____ State: _____ Zip Code: _____ Home Phone: (_____) _____

Cell Phone: (_____) _____ Email Address: _____@_____.com

Marital Status: ☐ Single ☐ Married ☐ Widowed Patient Resides with: ☐ Alone ☐ Spouse ☐ Parents ☐ Children ☐ Other: _____

# of Children: ☐ 0 ☐ 1 ☐ 2 ☐ 3+ How did you hear about us? _____ Date Symptoms Began: _____/_____/_____

Emergency Contact: _____ Relationship: _____ Phone (_____) _____

EMPLOYMENT

Employer's Name: _____ Occupation: _____ Work Phone (____) _____ Ext. _____

Work Address _____ City_____ State _____ Zip_____

CLAIM INFORMATION

Is Your Condition Due To: ☐Auto Accident ☐Personal Injury ☐Work Injury Other: _____

Type of Claim: ☐Self pay ☐Health Insurance ☐Personal Injury ☐Worker's Comp ☐Medicare ☐Medicaid

AUTHORIZATIONS

A. I consent to treatment necessary to my care.

B. I hereby authorize release of any medical information necessary to process this claim and request payment of insurance benefits either to myself or to the party who accepts assignment.

C. I authorize payment of any medical benefit from third parties for benefits submitted for my claim to be paid directly to this office. I authorize the direct payment to this office of any sum I now or hereafter owe this office by any attorney, out of proceeds of any settlement of my case and by any insurance company contractually obligated to make payment to me or you based upon the charges submitted for products and services rendered.

D. I understand and agree that health and accident policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that this office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to this office will be credited to my account upon receipt. However, I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees from products or professional services rendered will be immediately due and payable.

E. Our office, physicians and staff, are committed to securing the privacy of your health information. We are making available to you a copy of our Notice of Privacy Policies at your request.

F. Consent to treatment of a minor If applicable. If there are any circumstances when I am unable to bring my child to the office for his/her evaluation and treatment, I give permission and authorization to Adrian Chiropractic and its physicians and staff to administer examination and medical treatment as deemed necessary to him/her. Parent or Guardian Initial here: _____

G. I authorize Adrian Chiropractic and its physicians and staff to use the following additional contact information listed below to discuss or disclose information regarding any matters relating to my appointments, billing information and/or medical care.

You may release any of the info. above to the following person: Name: _____ Phone: _____

H. Please let us know which way you would like to receive your appointment reminders. You may choose either email **OR** text **OR** decline.

☐ Please send my messages to my cell phone: _____. My cell phone provider is _____.

☐ Please send my messages to my email: _____

☐ I decline being sent text or e-mail messages about my appointments.

I. We would like to thank you in advance for keeping your scheduled appointments and notifying our office of any changes. **Please be aware there is a $20 missed appointment fee.** Please give us a call before your appointment if you decide to cancel or reschedule to avoid this fee.

I fully understand and agree to all the Authorization statements stated above.

Patient/Guardian Signature: _____ Date: _____

Guardian Printed Name: _____ Relationship: _____