State Street Family Chiropractic

CONFIDENTIAL PATIENT INFORMATION
Welcome to our practice! Please complete all questions. Thank You.

Date:

Name: __Mr. __Miss __Mrs. __Ms.		Email: Ok to Email? Y / N	
Is this your legal name? Y / N If not, what is your legal name:		Former Name:	
Address:		Home Phone: Ok to leave message? Y / N	
City, State, Zip:		Cell: Ok to Text? Y / N	
Birth Date:	Age:	Sex: M F	Social Security #:
Marital Status: M W D S		Spouse's Name:	
You may share general information with the following person(s):			
Referred by:			
Employed by:		Occupation:	
Address:		Work Phone: Ok to Call? Y / N	
Who is financially responsible for this bill?			
Method of Payment: (Check One) ❑ Cash ❑ Check ❑ Credit Card ❑ Insurance Co.			

What brings you to our office today? _____

_____

_____

_____

_____

Indicate any function below that aggravate or are aggravated by your condition: (Circle all that apply)

Walking	Step Climbing	Driving Working	Working	Recreation	Bowel Movements	Digestion
Vision	Breathing	Sinuses	Hearing	Smelling	Sleeping	If Female, Menstrual

Have you ever been to a chiropractor before? ❑ Yes ❑ No If yes, when & where? _____

Was your experience good or bad? Please explain: _____

_____

_____

List all operations & major surgeries you have had:

_____

List all recent falls or accidents you have had:

_____

Is there any chance you are pregnant? ❑ Yes ❑ No

Medication you currently take: _____

Other comments: _____

_____

Confidential: Please make the doctor aware if you are HIV positive, or if you have any other communicable diseases, i.e., TB, Hepatitis.

OVER →

1. The fee paid for treatment x-rays is for analysis only. The film itself is the property of this office. Once films are used for treatment purposes they cannot be released. Copies may be made if necessary. The fee for these copies is $10.00

ASSIGNMENT AND RELEASE

I, the undersigned certify that I (or my dependent) have insurance coverage with _____

and assign directly to **Dr. Myco** 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 hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

1. I understand I am responsible for charges not covered or reimbursed by my health plan or similar payer. I agree to pay you directly if my insurer, health plan, employer program or similar benefit program does not pay.
2. I authorize my insurer, health plan, employer program or similar benefit program to release information to you regarding my coverage.
3. My right to payment for care, treatment, supplies and other services are hereby assigned to you. This assignment covers any and all benefits under Medicare, other government sponsored programs, insurance, employer programs and other health plans. I acknowledge this document as a legally binding assignment to collect my benefits as payment of claims for services. If my insurer, health plan, employer program or similar benefit program does not accept Assignment of Benefits, or is payments are made directly to my or my representative, I will endorse such payments to you.
4. I understand and **authorize release** of all health information about me to my insurer, health plan, employer program or similar benefit program identified above to **obtain payment** for care, treatment, supplies and other services. The above information is true to the best of my knowledge.

In case of emergency, please notify:

Name of local friend or relative not living with you: _____

_____ Home / Cell Phone: _____

Relationship to Patient

Work Phone: _____

_____ _____

Patient's Signature Date

_____ _____

Guardian's Signature Authorizing Care for Minor Date