Patient Confidentiality Personal Data

Patient: _____ Date: _____

Date of Birth: _____ SS#: _____-_____-_____ Email Address: _____

Home Address: _____ City: _____ State: ____ Zip: _____

Home Phone: ( ) _____ Work Phone: ( ) _____ Cell Phone: ( ) _____

Employer: _____ Address: _____

Name of Spouse: _____ SS#: _____-_____-_____ # of Children: _____

Emergency Contact: ( ) _____ Responsible for Payment: Self Spouse Other: _____

How did you bear about this clinic? _____

PATIENT'S INSURANCE

Name of Company: _____

Address: _____

ID & Group #: _____

Phone #: ( ) _____-_____

SPOUSE'S INSURANCE

Name of Company: _____

Address: _____

ID & Group #: _____

Phone #: ( ) _____-_____

What brings you here today (describe complaints)?

_____

_____

_____

Date symptoms began: _____ Was there an accident? Auto Job Fall None

Have you seen another Doctor for these complaints: Y N Name and Specialty: _____

Treatment Given: _____

Prescription medication and reason for taking: _____

CONSENT OF PROFESSIONAL SERVICES AND RELEASE OF INFORMATION

I hereby authorized the Doctor and whomever he/she may designate his/her assistants administer treatment, physical examination, X-Ray studies, laboratory procedures, chiropractic care or any clinic services that he/she deems necessary in my case. I further authorize him/her to disclose all or any part of my (patient's) record to any person or corporation which is or may be liable under a contract to the clinic or to the patient or to a family member or employee of the patient for all or part of the clinic's charges including, and not limited to, hospital or medical services companies, insurance companies, workers compensation carriers, welfare funds or the patient's employer.

Patient's Signature: _____ Witness by Physician: _____