



**Patient Information**

*Thank you for choosing our practice for your chiropractic needs. Please complete this form in ink. If you have any questions or concerns, do not hesitate to ask for assistance. We will be happy to help.*

**Demographics**

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ MI: \_\_\_\_\_

Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_ Gender: \_\_\_\_\_ SS# \_\_\_\_\_

Please circle: Married Single Other Employed Full time Student Part time Student

Home Address: \_\_\_\_\_ Apt #: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone #: \_\_\_\_\_ Work Phone #: \_\_\_\_\_

Cell Phone #: \_\_\_\_\_ Email: \_\_\_\_\_

Primary care physician? \_\_\_\_\_ How did you hear about us? \_\_\_\_\_

Can we enroll you in our free website membership? Circle one YES NO Where can we leave a message? \_\_\_\_\_

**Employment Information**

Employer Name: \_\_\_\_\_ Employer Phone #: \_\_\_\_\_

Employer Address: \_\_\_\_\_

Employer City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

**Emergency Contact**

Contact Name: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

Address: \_\_\_\_\_ Apt #: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone #: \_\_\_\_\_ Cell Phone #: \_\_\_\_\_

**My Certification**

**I certify that the above information is correct and I request services.**

X \_\_\_\_\_ Date  
Signature of patient or person acting on patient's behalf

**My Privacy**

I have received a copy of the Notice of Privacy Practices. I understand that I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to: Conduct, plan, and direct my treatment and follow-up among the healthcare providers who may be directly and indirectly involved in providing my treatment; Obtain payment from third-party payers; Conduct normal healthcare operations such as quality assessments and accreditation.

X \_\_\_\_\_ Date  
Signature of patient or person acting on patient's behalf

**Certification and Assignment**

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if I, or my minor child, ever have a change in health.

I certify that I, and/or my dependent(s), have insurance coverage with \_\_\_\_\_  
Name of Insurance Company(ies)

and assign directly to Dr. \_\_\_\_\_ all insurance benefits, if any, otherwise payable to me for services rendered. I understand that use of my signature on all insurance submissions.

The above-named doctor may use my health care information and my disclose such information to the above-named Insurance Company(ies) 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 complete or one year from the date signed below.

\_\_\_\_\_  
Signature of Patient, Patient, Guardian or Personal Representative

\_\_\_\_\_  
Date

\_\_\_\_\_  
Please print name of Patient, Guardian or Personal Representative

\_\_\_\_\_  
Relationship to Patient