Confidential Patient Information

Social Security No. ____________________

Driver's License No. ____________________

Date ____________________

Cell Phone: ____________

Name ________________________________ Home Phone: ____________

Address ________________________________ Zip Code ____________

Age ______ Birth Date ___/___/___ Marital Status: M S W D How many children? ____________

Occupation ________________________________ Employer ____________

Address ________________________________ Office Phone ____________

Name of Spouse ________________________________ Occupation ____________

Employer ________________________________ Office Phone ____________

Patient's Nearest Relative ________________________________ Address ____________

Referred By ________________________________ Date of Last Physical Exam ____________

CONSENT TO CARE

A patient coming to the doctor gives him/her permission and authority to care for the patient in accordance with appropriate tests, diagnosis, and analysis. The clinical procedures performed are usually beneficial and seldom cause any problem. In rare cases underlying physical defects, deformities or pathologies, may render the patient susceptible for injury. The doctor, of course, will not provide specific healthcare, if he/she is aware that such care may be contraindicated. It is the responsibility of the patient to make it known or to learn through health care procedures from whatever he/she is suffering from: latent pathological defects, illnesses, or deformities which would otherwise not come to the attention of the physician.

I have read and understand the foregoing.

____

Patient's Signature Date

PAYMENT IS EXPECTED AT TIME OF VISIT!

Name of Person Responsible for Payment ________________________________

Are You Insured? ☐ Yes/☐ No Company ____________ Phone ____________

I understand and agree that health and accident insurance policies are an agreement between an insurance carrier and myself. Furthermore, I understand that ____________ 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 ____________ will be credited to my account on receipt. However, I clearly understand and agree that all services rendered 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 for professional services rendered me will be immediately due and payable.

Patient's Signature ________________________ Date ____________

Guardian or Spouse's Signature ________________________ Date ____________

Information Taken By ________________________ Date ____________

Our consultation and examination may indicate that x-rays are necessary to accurately diagnose and analyze your spinal condition. Should x-rays be necessary we would like to confirm that you are not pregnant at this time.

Name: ______________________________

- ❑ There is a possibility that I may be pregnant at this time.
- ❑ Yes. I am definitely pregnant
- ❑ No. I am definitely not pregnant at this time
- ❑ I request that x-ray films not be taken because _____

_____

_____

Date of last menstrual period: ______________

____

Patient's Signature Date