Health First Chiropractic

HEALTH FIRST CHIROPRACTIC
CONFIDENTIAL INFORMATION

Contact Information

Name ____ Date ____________________

Address ____ City ______________________

State _______ Zip ___________ Hm Phone _________________ Cell Phone ________________

Email ____

Sex ______ Marital Status ______ Date of Birth _______________ Age _____ #Children _________

SS# ____________________ Occupation ________________ Employer ______________________

Employer Address _____________________________ Employer Phone ____________________

Spouse Name ___________________________________ Spouse Employer _________________

Name of Nearest Relative Other Than Spouse ________________________ Phone ____________

Office Information

Who referred you to our office? ____

Were you referred to a certain doctor in our office? _______________________________________

Is your visit due to an injury? □ No □ Yes *If yes, circle one*: Auto Work Other

(If this visit is due to a work or auto injury, please see the receptionist for a special injury form)

List your Primary Care Physician/Location: ____

May we contact them regarding your care? □ Yes □ No

Previous Chiropractor(s): ____

List any surgeries with dates: ____

Note any auto accidents with dates: ____

Insurance Information

Do you have insurance? □ Yes □ No Company ____

I.D. # ______________________________ Policy Group # ______________________________

I understand and agree that health and accident insurance policies are an agreement 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. I permit this office to endorse co-issued remittances for the conveyance of credit to my account. However, I clearly understand and agree that all services rendered me are charged directly to me and I am personally responsible for payment. It is my understanding that my credit may be checked if Health First Chiropractic extends credit to me and I understand that if I suspend or terminate care and treatment, any fees for professional services rendered me will be immediately due and paid unless other arrangements are made. I hereby authorize the doctors at Health First Chiropractic and whomever they may designate as their assistants; to administer treatments as they deem necessary and also authorize the release of any information acquired in the course of examination or treatment. I certify that the above information is true and correct.

Patient's (Parent or Guardian's) Signature: ____