



New Patient Application

Welcome to our office! Please complete all questions and sign where indicated.

Name:	Date:
Address:	City, State, Zip:
Home Phone:	Cell Phone:
Birth Date: Age:	E-Mail Address
Social Security #	Occupation:
Marital Status: S M D W	Employer:
Spouse's Name:	Spouse's Employer:
Children's Name/Ages:	Hobbies/ Interests:
Insurance Company:	Are you the policy holder?:

Current health complaints/reasons for visiting our office:

1. _____ 2. _____
3. _____ 4. _____

Who may we thank for referring you? _____

Have you had similar problems before? _____ How long? _____

Has anyone in your family had similar problems? _____ Who? _____

Other doctors you have seen for this concern: _____

Is this the result of an auto or work injury? _____ When?,How? _____

Surgeries you have had: _____

Current medications: _____

Is there a chance you are pregnant? _____

Have you ever been diagnosed with cancer? _____ What kind? _____

The above information is true and accurate to the best of my knowledge.

Patient or Guardian Signature: _____ Date: _____

AUTHORIZATION AND RELEASE: I authorize payment of insurance benefits directly to the chiropractor or chiropractic office. I authorize the doctor to release all information necessary to communicate with personal physicians and other healthcare providers and payors and to secure the payment of benefits. I understand that I am responsible for all costs of chiropractic care, regardless of insurance coverage. I also understand that if I suspend or terminate my schedule of care as determined by my treating doctor, any fees for professional services will be immediately due and payable. I understand that interest is charged on overdue accounts at the annual rate of (16%).

The patient understands and agrees to allow this chiropractic office to use their Patient Health Information for the purpose of treatment, payment, healthcare operations and coordination of care. We want you to know how your Patient Health Information is going to be used in this office and your rights concerning those records. If you would like to have a more detailed account of our policies and procedure concerning the privacy of your Patient Health Information we encourage you to read the HIPAA NOTICE that is available to you at the front desk before signing this consent. If there is anyone you do not want to receive your medical records, please inform our office.

Patient/Guardian Signature: _____

Relationship to Patient: _____ Date: _____