Patient Intake Form

Today's Date:____/____/____

Doctor/Provider you are seeing today:_____

Patient Full Name : _____ [ ] Male [ ] Female

****Marital Status: S M D W O**

Birth Date: _____/_____/_____ Age: _____ Social Security Number: _____/_____/_____

Address: _____ City: _____ State:_____ Zip_____

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

Email: _____

***Preferred method of contact:** CALL CELL CALL HOME CALL WORK

***How did you hear about us?(circle all that apply)** NEWSPAPER which one:_____

FRIEND name:_____ OTHER OFFICE which one:_____

INTERNET PHONEBOOK

OTHER:_____

Occupation: _____

Employer:_____

Emergency Contact: _____ Phone number:_____

Relationship to Contact:_____

Primary Care Provider: _____ When did you last see your primary doctor: _____

If injured, did it occur at: **Work [ ]** **Motor Vehicle Accident [ ]** Injury Date: _____

If *yes, PLEASE* let the front desk know, so we can be sure to get the proper information.

CONSENT FORM AND OFFICE POLICIES:

As a courtesy to you, this office will offer to verify your insurance coverage, and bill for services rendered. Benefits disclosed by the insurance company are not a guarantee of payment. If you do not have chiropractic insurance coverage, we offer a discounted fee if you pay at the time of service. Our regular fees are well within the normal range for this area, so neither you nor your insurance company will be billed unfairly.

It is not uncommon for insurance companies to delay payment for months, or to cut some or all charges as they see fit. In the event that payment is unreasonably delayed or reduced, you will be billed for the balance of your charges.

As with most health care procedures, there is some risk involved with treatment at this office. This rarely involves more than temporary muscle soreness after "treatment", but adverse reactions can be more severe than this. Please consult the doctor if you have any questions.

Signed: _____ Date: _____/_____/_____

(Patient, Guardian or Responsible Party)

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