Core Chiropractic, S.C.

Patient Information

Date:_____

Name:_____Social Security #:_____

Home Phone:_____Cell Phone:_____Work Phone:_____

Address:_____City, State, Zip:_____

E-mail address:_____

Age:_____Birth Date:_____

Race:_____Marital: M S W D

Height:_____Weight:_____

Occupation:_____Employer:_____

Employer's Address:_____

Spouse:_____

Spouse's Occupation:_____Spouse's Employer:_____

Name and Relation of nearest Relative:_____

Nearest Relative's Address:_____Phone:_____

How were your referred to our office?_____

Family Medical Doctor (first and last name):_____

When Doctors work together it benefits you. If needed, may we have your permission to update your medical Doctor regarding your care at this office? Yes No

Please check any and all insurance coverage that may be applicable in this case:

___Major Medical ___Worker's Compensation ___Medicaid ___Medicare ___Auto Accident

___Medical Savings Account and Flex Plans _____Other___None

Name of Primary Insurance Company:_____

Name of Secondary Insurance Company (If any):_____

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 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.

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 a more detailed account of our policies and procedures concerning the privacy of your Patient Health Information we encourage you to read the HIPAA Notice that is given 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's Signature:_____Date:_____

Guardian's Signature Authorizing Care:_____Date:_____