

River Ridge Chiropractic

Patient Intake Form

Name _____ Date of Birth _____

Social Security # (required if using insurance) _____ Ht _____ Wt _____

Street/PO _____ City _____ St _____ Zip _____

Cell Phone _____ Home Phone _____ Work Phone _____

TEXT Reminder - YES _____ **NO** _____

Home Email _____

Employer's Name _____ Position _____

Employer's Address _____

Emergency Contact _____ Phone _____

Relationship _____ Referred by _____

Reason for visit: _____

Date symptoms began _____ Have you been treated for this condition? _____

If **yes**, please describe _____

Are you taking any medications? _____ If yes, please list _____

Date of last physical _____ Name of current Physician _____

List any **recent (since last visit)** surgeries, illnesses, accidents, falls, etc. _____

Person responsible for payment (if other than patient) _____

Insurance Company _____

*Policy Holder's Name _____ *DOB _____

*Policy Holder's Address _____

*Relationship to Policy Holder _____ Policy Holder's Employer _____

Insurance Information

I understand and agree that health insurance policies are an agreement between an insurance carrier and myself. Furthermore, I clearly understand that this chiropractic office will prepare my necessary reports, and that any amount authorized to be paid directly to this chiropractic office will be credited to my account on receipt. However, I clearly understand and agree that all services rendered to me are charged directly to me and 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 to me will be immediately due and payable.

Consent of Professional Services and Release of Information

I hereby authorize the doctor and whomever he may designate as his assistants to administer treatment, physical examination, x-ray studies, laboratory procedures, chiropractic care, or any clinic services that he deems necessary in my case, and I further authorize him to disclose all or any part of the clinic's record to any person or corporation which is liable under a contract to the clinic or to the patient for all or part of the clinic's charge including but not limited to hospital or medical services companies, insurance companies, workers compensation carriers, welfare compensation carriers or the patient's employer.

Patient (or) Guardian Signature _____

Today's Date _____

*We MUST have subscriber's/policy holder's information to file your insurance. Thank you!