River Ridge Chiropractic

Patient Intake Form

Name_____ Date of Birth_____

Social Security # (required if using insurance) _____ Ht_____ Wt_____

Address_____ City_____St_____Zip_____

Home Phone_____ Cell Phone _____ Work Phone_____

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 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_____

Date_____