PATIENT PERSONAL / CONFIDENTIAL DATA

Patient No. _____ **Email:** _____ **Date** _____

Patient Name: _____

Home Address: _____ **City:** _____ **State:** _____ **Zip:** _____

Social Security No.: _____ **Date of Birth:** _____

Home Phone: _____ **Cell Phone:** _____

Employer: _____ **Work Phone:** _____

Name of Spouse: _____ **Date of Birth:** _____ **No. of Children:** _____

How did you learn of this clinic? _____

Nearest relative not living with you? _____ **Phone:** _____

Who is responsible for payment? ❑ **Self** ❑ **Spouse** ❑ **Other**

Purpose of this appointment and list your complaints: _____

_____

When did condition start: _____ **Time:** _____ ❑ **AM** ❑ **PM Location:** _____

If you had an accident, how did accident occur? ❑ **Auto** ❑ **On the job** ❑ **Other:** _____

Please describe your condition(s) and what makes it better or worse:: _____

_____

_____

Allergies: _____

Other Doctor seen for this condition: _____

Have you been treated by a Doctor for any health condition in the last year? ❑ **Yes** ❑ **No**

If yes, please describe: _____

INSURANCE INFORMATION

I understand and agree that health and accident insurance policies are an agreement between an insurance carrier and myself. Furthermore, I understand that this Chiropractic Office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to this Chiropractic Office will be credited to my account upon receipt. However, I clearly understand and agree that all services rendered to me are charged directly to me and that 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.

Signature Physician: _____ **Signature Patient:** _____

CONSENT OF PROFESSIONAL SERVICES AND RELEASE OF INFORMATION

I hereby authorize and release the doctor and whom ever heaths may designate as his/her assistants to administer treatment, physical examination, X-Ray studies, laboratory procedures, chiropractic care or any clinic services that he/she deems necessary in my case; and I further authorize him/her to disclose all or any part of my (patient's) record to any person or corporation which is or may be liable under a contract to the clinic or to the patient or to a family member or employer of the patient for all or part of the clinic's charge, including, and not limited to, hospital or medical services companies, insurance companies, workers compensation carriers, welfare funds, or the patient's employer.

NOTICE OF PRIVACY PRACTICES

I hereby acknowledge that I have read and had an opportunity to ask questions concerning Villines Chiropractic's Notice of Privacy Practices.

Patient's Signature: _____

Parent's or Guardian's Signature: _____