Office Use (Revised July 2014)

_____

LANCASTER CHIROPRACTIC REHAB CENTER

Social Security # _____

CONFIDENTIAL PATIENT INFORMATION

E-Mail Address _____

Legal Name _____ Home Phone _____ Cell Phone _____
(First) (M.I.) (Last)

Address _____ City _____ State _____ Zip Code _____

Age _____ Birth Date _____ Marital Status: M S W D How many Children? _____

Occupation _____ Employer _____ Work Phone _____

Address _____ City _____ State _____ Zip Code _____

Name of Wife or Husband _____ Birth Date _____ Occupation _____

Employer _____ Family Doctor _____ May We Contact? _____ Yes _____ No

Patient's Nearest Relative _____

Address _____ City _____ State _____ Zip Code _____

Referred By _____ Date of Last Physical Examination _____

Have You Ever Suffered From:

	YES	NO		YES	NO
1. Dizziness	____	____	8. Asthma	____	____
2. Backaches	____	____	9. Neuritis	____	____
3. Heart Trouble	____	____	10. Digestive Disorders	____	____
4. Diabetes	____	____	11. AIDS or HIV+	____	____
5. Stroke	____	____	12. Sinus Trouble	____	____
6. Arthritis	____	____	13. Anemia	____	____
7. Headaches	____	____	14. Cancer	____	____

Purpose of this appointment _____

Other doctors seen for this condition _____

Have you been treated for any health condition by a physician in the last year? YES NO

Describe: _____

PAYMENT IS EXPECTED AT THE TIME OF VISIT

Name of Person Responsible for Payment: _____

Are You Insured? YES NO Company: _____ Group No. _____

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that the Lancaster Chiropractic Rehab Center will prepare any necessary forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to the Lancaster Chiropractic Rehab Center will be credited to my account on receipt. However, I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I understand that no guarantee has been made as to the results of treatment and I understand that if I suspend or terminate my care and treatment, any fees for professional services rendered will be immediately due and payable. No charge for consultation; does not include exam, x-rays, treatment or any other services. I acknowledge & understand that I have the option of having a third party present during my exam(s). I hereby give my consent to receive e-mail newsletters from this office. By signing this Confidential Patient Information sheet, I acknowledge I received a copy of same.

I hereby authorize the doctor to release all my medical information necessary to process my claims. I also authorize any plan administrator or fiduciary, insurer and my attorney to release to such doctor and clinic any and all plan documents, insurance policies, Summary Plan Description and/or settlement information upon written request from such doctor and clinic in order to claim such medical benefits, reimbursement or any applicable remedies. I hereby authorize the doctor to release any and all medical information to other healthcare providers involved in my care including but not limited to my primary care physician. I authorize the use of this signature on all my insurance and/or employee health benefits claim submissions.

Patient's Signature: _____ Date: _____

Guardian or Spouse's Signature: _____ Date: _____

Information Taken By: _____ Date: _____