

Hackbart Chiropractic PATIENT INFORMATION

(Please Print)

Patient# _____

Today's date:	Doctor:
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PATIENT INFORMATION

Patient's last name:	First:	Middle:	<input type="checkbox"/> Mr. <input type="checkbox"/> Mrs.	<input type="checkbox"/> Miss <input type="checkbox"/> Ms.	Marital status (circle one) Single / Mar / Div / Sep / Wid
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How many children do you have?	Their names & ages?	Birth date: / /	Age:	Race:	Sex: <input type="checkbox"/> M <input type="checkbox"/> F
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Street address:	Social Security no.:	Home phone#: ()
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P.O. box:	City:	State:	Cell phone#: ()
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Occupation:	Employer:	Employer phone no.: ()	Fax # ()
			E-mail Address:

How were you referred to our office? _____

Spouse's Name:	Occupation:	Employer:
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INSURANCE INFORMATION

(Please give your insurance card to the receptionist.)

Person responsible for bill:	Birth date: / /	Address (if different):	Home phone no.: ()
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Is this person a patient here? Yes No

Is this patient covered by insurance? Yes No

Please indicate primary insurance _____

Subscriber's name:	Birth date:	Group no.:	Name of Family Medical Doctor:
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Patient's relationship to subscriber: Self Spouse Child Other

Name of secondary insurance (if applicable):	Subscriber's name:	Group no.:	Policy no.:
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Patient's relationship to subscriber: Self Spouse Child Other

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address):	Relationship to patient:	Home phone no.: ()	Work phone no.: ()
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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 I am responsible for all costs of chiropractic care, regardless of insurance coverage. I also 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. I understand that interest is charged on overdue accounts at the annual rate of 16%

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 to have a more detailed account of our policies and procedures concerning the privacy of your Patient Health Information we encourage you to read the HIPPA NOTICE that is available 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.

<hr style="border: none; border-top: 1px solid black;"/> <p><i>Patient/Guardian signature</i></p>	<hr style="border: none; border-top: 1px solid black;"/> <p><i>Date</i></p>
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