HAUPTMAN CHIROPRACTIC CLINIC

PATIENT CONFIDENTIALITY PERSONAL DATA

Date:_____

Patient:_____ Date of Birth:_____
Home Address:_____ City:_____ State:____ Zip:_____
Social Security #:_____ Home Phone:_____ Cell Phone: _____
Work Phone: _____ Email:_____
Employer:_____ Address:_____

Spouse:_____ S. S. #:_____ No. of Children:_____
Employer:_____ Address:_____
How did you learn of this clinic:_____
Person to contact in case of emergency (other than spouse):_____Phone: _____

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:_____

Patient's Insurance **Spouse's Insurance**
Name of Company: _____ Name of Company:_____
Policy #:_____
Group #:_____

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 on 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.

Patient Signature: _____ Signature Physician: _____

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/she deems necessary in any 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.

Patient's Signature: _____
Parent's or Guardian's Signature**: _____**