CONFIDENTIAL PATIENT INFORMATION

Name: _____
Address: _____
City: _____State:___ Zip:_____
Home Ph#: _____Cel Ph#: _____
E-mail: _____
Age:___ Birth Date:_____ Sex: F M
Social Security Number: _____
Driver License #: _____
Marriage Status: M S W D No. Children:____

How did you hear about our office?_____

Family Physician: _____
Address: _____
Phone: _____

	Circle one	If Yes, Date:
Is this condition due to injury or illness?	Yes No	_____
Is this condition due to an auto accident?	Yes No	_____
Did your injury occur while at work?	Yes No	_____

Occupation: _____ How long? ____
Employer: _____
Address: _____
City: _____State:___ Zip:_____
Work Phone: _____

Spouse's Name: _____
Occupation: _____
Employer: _____

Patient's Nearest Relative: _____
Relationship: _____
Address: _____
City: _____State:___ Zip:_____
Phone number:_____

Who should we contact in case of emergency?
_____
Address: _____
City: _____State:___ Zip:_____

INSURANCE INFORMATION

Do you have group, union, personal health or accident insurance? Yes No
Are you covered by medicare? Yes No Medicare # _____

PRIMARY INSURANCE CO: _____
Address: _____
City: _____State:___ Zip:_____
Phone: _____
Insured person: _____
Insured's SS #: _____
Policy ID/No.:_____
Group /Claim No.: _____

SECONDARY INSURANCE CO: _____
Address: _____
City: _____State:___ Zip:_____
Phone: _____
Insured person: _____
Insured's SS #: _____
Policy ID/No.:_____
Group /Claim No.: _____

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures including various modes of physical therapy and diagnostic x-rays, on me (or on the patient named above, for whom I am legally responsible) by the doctor of chiropractic named below and/or other licensed doctors of chiropractic who now or in the future treat me while associated in any way to the doctor of chiropractic named below, including those working at the office of the doctor of chiropractic named below. I have had an opportunity to discuss with the doctor of chiropractic named below and/or with other office or clinic personnel the nature and purpose of chiropractic adjustments and other procedures. I understand that the results are not guaranteed.

I understand and am informed that, as in the practice of medicine, in the practice of chiropractic there are same risks to treatment, including, but not limited to fractures, disc injuries, strokes, dislocations, and sprains. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely on the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known, is in my best interest.

By my signature below I admit to understanding the foregoing statement and agree to the above-named procedures. I have also had an opportunity to ask questions about its content. I intend this consent to cover the entire course of treatment for any condition now or in the future for which I seek treatment. Health and accident insurance policies are an arrangement between the carrier and the patient, and are usually designed to offset a large portion of the total cost of care. This office will help prepare any necessary reports and forms to assist in making collections from the insurance company to the patient. Authorized reimbursements paid directly to this office will be credited to the patient's account or reimbursed to the patient if in excess. It should be understood that all services furnished are charged directly to the patient. In addition, if the patient terminates care, all fees for professional services are due immediately.

I agree that the forgoing information is accurate to the best of my knowledge. In addition, I understand and agree that I am personally responsible for payment of services furnished for my care. I hereby assign my major medical insurance benefits, private insurance, and other health plans to Wayne R. Nelson, DC and Condition For Life. I also authorize the release of any information required to secure payment.

Patient's Signature(Guardian if minor): _____ Date: _____