Welcome to Atlas Chiropractic

PATIENT:

Last Name:______________________________ First Name:__________________________M.I.__________

Gender: M F Date of Birth:___/___/___ SS#______________________ Marital Status: M S D W

Home Address:____Apt#__________________

City:_________________________________ State:__________________ Zip:_______________________

Home Phone:________________________________ Work Phone :____________________________

Employer Name:_______________________________________ Occupation:_______________________

HEALTH INFORMATION:

Past Chiropractic care? yes no If yes, date of last adjustment:_____________________

Is injury due to work?___________________ auto?_______________ other accident?__________________

Date of Injury:______________________ Brief description of accident:______________________________

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Please list any surgeries, severe past injuries/accidents, current medications, etc:___________________

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Reason for seeing Dr. today:____

Family Physican:___________________________ Referred by:________________________________

INSURANCE: (Please present card)

Insurance Company:____________________________________ Phone :____________________________

Insured's Name:_________________________________ ID/Policy#:____________________________

Group #:____________________________________Workers Compensation:__________________________

Phone:_________________________________ Claim#:____

SIGNATURE:(Patient, Parent, Legal guardian or Responsible Party)

I understand that care received and fees stemming from this care are ultimately my responsiblity. If covered by insurance, I understand that all procedures performed may not be covered and I may also have co-pays and/or deductibles to be met. I further understand that interest and/or penalties may apply for accounts past due (over 30 days). Further, I understand that if I pay for care at time of service I will receive a bookkeeping discount. Our regular fees will apply for those who are billed and/or insurance carriers that are billed. I grant permission to my Insurance Co. to pay Atlas Chiropractic directly for services rendered. If during the course of a chiropractic spinal examination, we encounter non-chiropractic or unusual findings, we will advise you. If you desire advice, diagnosis or treatment for those findings, we will recommend that you seek the services of another health care provider.

I understand and agree **Signed:**______________________________________ **Date:**____________________

PAYMENT METHOD: ☐ Cash ☐ Check ☐ Visa ☐ Mastercard ☐ Discover ☐ Bill my Insurance