WISE CHIROPRACTIC

PATIENT APPLICATION FOR TREATMENT

First Name: _____ M.I.: _____ Last Name: _____

What do you prefer to be called: _____ DOB: _____ Age: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Home #: _____ Cell#: _____ Other: _____

SS#: _____ Sex: _____ Single\Married\Divorced\Widow

Spouse Name: _____ Email: _____

Emergency Contact: _____ T#: _____

Initials _____ I instruct the chiropractor to deliver the care that, in his or her professional judgement, can best help me restoration of my health. I also understand that the chiropractic care offered in this practice is based on the best available evidence and designed to reduce or correct vertebral subluxation. Chiropractic is a separate and distinct healing art from medicine and does not proclaim to cure any named disease or entity.

Initials _____ I may request a copy of the privacy policy and understand it describes how my personal health information is protected and released on my behalf for seeking reimbursement from any involved third parties.

Initials _____ I realize that an x-ray examination may be hazardous to an unborn child, and I certify that to the best of my knowledge I am not pregnant. Date of last menstrual period (MM/DD/YYYY):_____

Initials _____ I grant permission to be called or texted to confirm or reschedule an appointment and to be sent occasional cards, letters, email, or PHI to me as an extension of my care in this office.

Initials _____ I acknowledge that any insurance I may have is an agreement between the carrier and myself and that I am responsible for the payment of any non-covered services I receive.

Initials _____ To the best of my ability, the information I have supplied is complete and truthful. I have not misrepresented the presence, severity or cause of my condition

_____ _____

Signature Date