

Wiederrich Chiropractic Clinic

Confidential Patient Information Form

Today's Date _____

Name _____ Date of Birth _____ Marital Status: M S W D

Address _____ City _____ Zip _____

Email _____ Mobile Phone (____) _____

Home Phone (____) _____ Work Phone (____) _____

Employer _____ Occupation _____

Name of spouse _____ Spouse's Employer _____

Emergency contact name _____ Contact Phone (____) _____

Relationship of emergency contact (Parent/ Other Relative/Friend) _____

Referred By (circle): Yellow Pages / Provider Manual / Other physician / Friend or relative

Name _____

Date of last physical examination _____

Reason for your visit today? _____

Is your visit the result of an auto or work injury? Y/N If yes, which _____

Have you seen other doctors or chiropractors for this problem? Y/N If yes, who _____

Are you currently taking any medications (Prescribed or "Over the Counter")? _____

Additional information _____

PAYMENT IS EXPECTED AT THE TIME OF SERVICE

PAYMENT / INSURANCE INFORMATION

Name of person responsible for payment _____

Are you insured? Y/N Company _____

Would you like us to bill your insurance Y/N

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that the Wiederrich Chiropractic Clinic 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 the Wiederrich Chiropractic Clinic will be credited to my account on receipt. However, I clearly understand and agree that all services rendered me are charged directly to me and 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 me will be immediately due and payable. With my signature I hereby state that all of the above information was truthful and accurate to the best of my knowledge.

Patient's Signature: _____ S.S. # _____ - _____ - _____ Date _____

Guardian's Signature Authorizing Care: _____ Date _____