

# Wiederrich Chiropractic Clinic

## Confidential Patient Information Form

Today's Date \_\_\_\_\_

Name \_\_\_\_\_ Date of Birth \_\_\_\_\_ Age \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone (     ) \_\_\_\_\_ Marital Status: M S W D Children Y/ N # \_\_\_\_\_

Occupation \_\_\_\_\_ Employer \_\_\_\_\_

Address \_\_\_\_\_ Work Phone \_\_\_\_\_

Name of spouse \_\_\_\_\_ Occupation \_\_\_\_\_

Employer \_\_\_\_\_ Work Phone \_\_\_\_\_

Emergency contact \_\_\_\_\_ 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 \_\_\_\_\_