WELCOME TO OUR OFFICE

DATE: ______________ **ACCOUNT#:**____________

NAME: ___________________________________ **AGE:** ____ **BIRTHDATE:** ___/___/___

ADDRESS: ________________________________ **SS#:**______-_____-_______ **M:** ___ **F:** ___

CITY: __________________________ **STATE:**______________ **ZIP:**________________

HOME PHONE#:__________________________ **CELL PHONE#:**________________

E-MAIL ADDRESS: ____

EMPLOYER: _______________________________ **WORK PHONE#:**_______________

MARITAL STATUS: ___SINGLE ___ MARRIED___SEPARATED___DIVORCED___WIDOWED

RACE: ___ WHITE ___AFRICAN AMERICAN___ASIAN___OTHER, EXPLAIN: _______________

ETHNICITY: ___HISPANIC___NON-HISPANIC **PRIMARY LANGUAGE SPOKEN:**__________

LOCATION OF PAIN: ____

WHEN DID THE PAIN BEGIN: ____________________ ACCIDENT RELATED: ___YES ___NO

IF YES, WHAT TYPE OF ACCIDENT: ___AUTOMOBILE___WORK RELATED___OTHER

IF OTHER, WHAT TYPE OF ACCIDENT: ____

HOW WERE YOU REFERRED TO OUR OFFICE? ____YELLOW PAGES____TV/AD____SIGN

____FRIEND/RELATIVE____

INSURANCE COMPANY: ____

INSURED'S NAME: ____________________ MEMBER ID#: ______________GROUP#:______________

IN EVENT OF EMERGENCY

NAME: _________________________________ PHONE#:______________________________

NAME: _________________________________ PHONE#:______________________________

In regards to our offer of 2 complimentary x-rays, please note that some limitations do apply. ***Complimentary services are not available to you if you are seeking treatment due to a personal injury or work related accident.*** **X-rays consist of 2 views of the same area of the spine. These x-rays shall remain the property of Chiropractic Clinic of Gretna, Inc. A copy of the x-rays can be made available to you at a duplication charge equal to the value of the x-rays.**

By my signature below, I state that I understand the above limitations with regards to the 2 complimentary x-rays.

____

Patient Signature

PLEASE CONTINUE ON BACK

ACCOUNT INFORMATION:

PERSON RESPONSIBLE FOR PAYMENT OF ACCOUNT: ______________________________

BILLING ADDRESS (IF DIFFERENT):____

SS#: _____-_____-_____ DRIVER'S LICENSE#: ____________________

ASSIGNMENT OF BENEFITS:

___ I HEREBY AUTHORIZE ASSIGNMENT OF MY INSURANCE RIGHTS AND BENEFITS DIRECTLY TO **CHIROPRACTIC CLINIC OF GRETNA, INC.** FOR SERVICES RENDERED.

Unless other arrangements have been made, our office policy requires payment for all medical services rendered at the time of you visit. All supplies, supports, supplement, etc. must be paid for at the time of your purchase. **NO REFUNDS WILL BE MADE FOR SUCH ITEMS PURCHASED.**

If your financial status or insurance carrier changes, or the current arrangements need to be changed, please do not hesitate to discuss this with us.

AUTHORIZATION TO TREAT:

I hereby authorize the Doctors and Staff of Chiropractic Clinic of Gretna, Inc. to perform any necessary services needed during diagnosis and treatment.

PROVISIONS TO TREAT:

I hereby appoint this Chiropractic Clinic of Gretna, Inc. and any of its duly authorized agents, to serve as lawful attorney invested with all powers and authority necessary to endorse and cash any checks, drafts, or monies which are made payable to me.

MEDICAL RELEASE:

I authorize the release of any information pertinent to my case to any insurance company, adjuster, or attorney involved in this case.

I understand the above information and guarantee this form was completed correctly, to the best of my knowledge. I understand it is my responsibility to inform this office of any changes in my medical status.

____________________________________ ____________________________________

Patient Signature (If minor, parent must sign) Witness

Date: ___/___/____