THANK YOU FOR SELECTING US!

To help us meet all your healthcare needs, please fill out this form completely. Please print clearly.

DATE: ________ / ________ / ________ Account #: ______________________________________

NAME: ________________________________ AGE: ___ BIRTHDATE: ______ / ______ / ______

ADDRESS: ____________________________________ SS#: __________________________

CITY: __________________________ STATE: ___ ZIP: ________ PHONE: ___________________

EMAIL: ____

EMPLOYER ____ PHONE: ___________________

MARITAL STATUS: _____ Single _____ Married _____ Separated _____ Divorced _____ Widowed

SPOUSE'S NAME: _______________________ BIRTHDATE: ____ / ____ / ____ SS#: ______________

EMPLOYER ____ PHONE: _________________

YOUR PRESENT COMPLAINT: ____

When did this complaint begin?: ______________________ Accident related?: ________________

If yes, what type of accident?: _____ Automobile _____ Work related _____ Other

If other, please explain: ____

INSURANCE COMPANY: ____

PHONE: ___________________ INSURED: ___________________ GROUP #: ___________________

SECONDARY INSURANCE INFORMATION: (IF APPLICABLE)

INSURANCE COMPANY: ____

PHONE: ___________________ INSURED: ___________________ GROUP #: ___________________

IN EVENT OF EMERGENCY: (2 PEOPLE, NOT LIVING WITH YOU)

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 Dr.Celine.com. 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

ACCOUNT INFORMATION:

PERSON RESPONSIBLE FOR PAYMENT OF ACCOUNT: ________________________________

BILLING ADDRESS (IF DIFFERENT): ____

SS#: ______________________________ DRIVER'S LICENSE: ____________________________

PAYMENT METHOD: _____ CASH _____ CHECK _____ CREDIT CARD (TYPE) _______________

ACCT #: ________________________ EXP. DATE: ______ / ______

ASSIGNMENT OF BENEFITS:

I HEREBY AUTHORIZE ASSIGNMENT OF MY INSURANCE RIGHTS AND BENEFITS DIRECTLY TO DR.CELINE.COM FOR SERVICES RENDERED.

Unless other arrangements have been made, our office policy requires payment for all medical services rendered at the time of your visit. All supplies, supports, supplements, 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 Dr.Celine.com to perform any necessary services needed during diagnosis and treatment.

PROVISIONS FOR PAYMENT:

I hereby appoint this Dr.Celine.com. 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 in formation 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: ______ / ______ / ______