

Todd B. Andrews, D.C.
206 S. Placentia Ave.
Placentia, CA 92870
(714) 572-3834

Date _____

PLEASE PRINT

PATIENT INFORMATION

Name _____
Address _____
City _____ Zip _____
Birth Date _____ Sex M F
Home Phone # _____
Cellular Phone # _____
Social Security # _____
Driver License # _____
Marital Status _____
Email Address _____
Referred By _____

EMPLOYER INFORMATION

Occupation _____
Employer _____
Employer Address _____
City _____ Zip _____
Business Phone # _____ ext. _____

REASON FOR CONSULTATION

What are your present complaints and symptoms?

Is your condition a result of a: Work injury? _____
Auto accident? _____
Other _____
Date of injury or onset _____
Family Physician _____
Phone # _____

AUTHORIZATION TO PAY BENEFITS TO PHYSICIAN

I hereby authorize payment of benefits be made directly to this healthcare provider and I understand that I am responsible for charges not covered by this assignment. I also authorize the release of any information requested to process this claim.

Signed _____
(Insured Person)

RESPONSIBLE PARTY INFORMATION

(if other than self)
Name _____
Relationship to Patient _____
Social Security # _____ DOB _____
Home Phone # _____
Cellular Phone # _____
Work Phone # _____
Address _____
City _____ Zip _____
Employer's Name _____
Address _____
City _____ Zip _____
Occupation _____
If patient is a child, name of other parent _____
Address _____
City _____ Zip _____
Home Phone # _____
Work # _____

INSURANCE INFORMATION

Are you insured? Y N
(Please present insurance card to receptionist)
Insurance Company _____
Other Insurance Company _____

EMERGENCY CONTACT

Name _____
Relationship _____
Phone # _____

CONSENT TO TREATMENT OF A MINOR

I (we) being the parent or guardian of the above patient, a minor, the age of _____, do hereby consent, authorize and request Dr. Andrews and whomever he may designate as his assistant, to administer such treatment deemed advisable, necessary or requested for this minor.

Signed _____
(Parent or Legal Guardian)

Date _____