

**MILLSPAUGH CHIROPRACTIC
PATIENT CONFIDENTIALITY PERSONAL DATA**

Patient Name: _____ Date of Birth: _____

Home Address: _____ City: _____ State: _____ Zip: _____

Social Security No.: _____ Email: _____

Home Phone: _____ Employer: _____ Work Phone: _____

Mobile Phone: _____ Check box to Opt-in to receive texts- birthday,
schedule changes, appointment notices, etc.

How did you learn of this clinic? _____

Who is responsible for payment? Self Spouse Other _____

PRIMARY INSURANCE

SECONDARY INSURANCE

Name of Company: _____ Name of Company: _____

ID No.: _____ ID No.: _____

Group No.: _____ Group No.: _____

Purpose of this appointment and list your complaints: _____

Date of illness: _____ Time: _____ Location: _____

How did accident occur? Auto On the job Other _____

Please describe the circumstances and what makes the condition better or worse: _____

Other doctor seen for this condition: _____

Have you been treated by a doctor for any health condition in the last year? Yes No

If yes, please describe: _____

INSURANCE INFORMATION

I understand and agree that health and accident insurance policies are an agreement between and insurance carrier and myself. Furthermore, I understand that this Chiropractic Office 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 this Chiropractic Office will be credited to my account on receipt. However, I clearly understand and agree that all services rendered to me are charged directly to me and that 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 to me will be immediately due and payable.

Patient Signature: _____ Physician Signature: _____

CONSENT OF PROFESSIONAL SERVICES AND RELEASE OF INFORMATION

I hereby authorize the doctor and whomever he may designate as his assistant to administer treatment, physical examination, x-ray studies, laboratory procedures, chiropractic care or any clinic services that he/she deems necessary in any case; and I further authorize him/her to disclose all or any part of my (patient's) record to any person or corporation which is or may be liable under a contract to the clinic or to the patient or to a family member or employer of the patient for all or part of the clinic's charge, including, and not limited to, hospital or medical services companies, insurance companies, workers compensation carries, welfare funds, or the patient's employer.

Patient Signature: _____ Parent or Guardian Signature: _____