SPINAL HEALTH PERFORMANCE, INC.
4 Harvard Cir, Ste 700, West Palm Beach, FL 33409 561-684-9200/fax 561-684-9202

PATIENT INFORMATION:	
Name:	Home Phone:
Nickname:	Work Phone:
Address:	Cell Phone:
Address:	Cell Phone Carrier:
City:	Email:
State: Zip:	Contact Preference: circle one
Social Security #:	home work cell text email
Gender: circle one M F	Emergency Contact:
Marital Status: circle one S M D W Separated	Emergency Contact Phone#:
Spouse Name:	Referred by:
Your Date of Birth: Age:	Entered by (for staff use only):
Occupation:	Employer:

RACE/ETHNICITY:
Race: circle one White Black/African American More than 1 race Prefer to not disclose Other:_____
Ethnicity: circle one Hispanic/Latino Not Hispanic/Latino Prefer to not disclose Other:_____

INSURANCE/GUARANTOR INFORMATION:	
Primary Health Ins:	Secondary Insurance:
Subscribed Name:	Auto Insuarnce:_____
Subscriber date of birth:	claim#

Disclaimer and Informed Consent:

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that this 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 office will be credited to my account upon receipt. I permit this office to endorse co-issued remittances for the convenience of credit to my account. However, I clearly understand and agree that all services rendered 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 me will immediately be due and payable.
I hereby request and authorize Spinal Health Performance Inc. to perform diagnostic tests and give treatment as deemed necessary. By signing below, I state that I have weighed the risks involved in undergoing treatment and have my self decided that it is in my best interest to undergo the treatment

Patient's Signature:	Date:
Witness:	Date:

If the patient is a minor, permission is hereby given by me to the doctors of this office and whomever they designate to treat the patient. I am his/her legal guardian.

Guardian's Signature:	Date: