Confidential Patient Information

The following information is needed for our files so we can serve you as a patient. Please fill in all portions of this form.
If you need any help please ask the receptionist. PLEASE PRINT

1) Your Name:	Name: Last First MI	Home/Message Phone ( )
	Street Address	Work Phone ( )
	City State Zip	Cell Phone ( )
	Age / Birth Date / Sex circle one M F / Marital Status circle one S M D W Separated	Social Security Number - -
2) Employment:	Employer (co. name) If Self-Name of Business	Occupation/Title/Rank
	Address City State Zip	Email Address
3) Spouse Or Parent (if minor)	Spouse's Name/Parent's Name	
	Address (if different from above) City State Zip	
4) Referral Source	Who Can we Thank for Referring you to our office?	Entered by(for staff use only):
5) Insurance Information	Primary Insurance Company Name	Secondary Insurance Company Name
	Primary Insured's Name	Primary Insured's Date of Birth
please provide copy of insurance card(s)	Primary Insured's Address	Primary Insured's Social Security No. - -
6) Emergency Contact	Name and Relationship to you	Phone Number ( )

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 myself decided that it is in my best interest to undergo the treatment recommended. Having been informed of the risks, I hereby give my consent to that treatment.

6) Patient's Signature		DATE:
7) 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.

8) Guardian Signature		DATE: