Dunne Chiropractic

Date ____________________

CONFIDENTIAL PATIENT INFORMATION

Name ________________________________ Home Phone _____________ Cell Phone ______________

Address ______________________________ Town ___________________ Zip Code ______________

Age ________ Birth Date _______________ Marital Status M S W D How many children _______

Email Address _______________________________ Social Security Number _______________________

Occupation _________________________________ Employer __________________________________

Work Address ______________________________________ Work Phone __________________________

Name of Spouse ______________________________ Spouse's Occupation _________________________

Spouse's Employer ___________________________ Address ____________________________________

Referred Here By ____

Purpose of this Appointment (major complaint) ____

Name of General Physician/Family Doctor ____

Physician Address _______________________________ City ______________________ State ________

Physician Phone # ________________________ Last Time You Saw Family Doctor _________________

Are you insured ❒ Yes ❒ No Name of Insurance Company __________________________________

Insured's Name __________________________________ Insured's Date of Birth ___________________

Insured's Social Security Number (If Different From Above) ____________________________________

Relation to Insured ________________________ Do you have an HSA/FSA account?________________

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that Dunne Chiropractic will prepare any necessary forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to Dunne Chiropractic will be credited to my account on receipt. 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 be immediately due and payable. I also understand that if a collection service must be retained any and all collection fees will be my responsibility.

Patient's Signature ____ Date __________________________

Guardian's Signature ______________________________________ Date __________________________