

Patient's Name \_\_\_\_\_

Date of Birth \_\_\_\_\_

# WELCOME

Thank you for selecting our healthcare team! We will strive to provide you with the best possible healthcare. To help us meet your entire healthcare needs, please fill out this form completely in ink. If you have any questions or need assistance, please ask us, we will be happy to help.

## 1. PERSONAL INFORMATION

Date \_\_\_\_\_ Birth date \_\_\_\_\_ Soc. Sec # \_\_\_\_\_

Last Name \_\_\_\_\_ First Name \_\_\_\_\_

Nickname \_\_\_\_\_ Gender: Male Female

Marital Status: Single Married Other Children \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Email address \_\_\_\_\_

Employer \_\_\_\_\_ Occupation \_\_\_\_\_

Employer's Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

How did you hear about us? \_\_\_\_\_

## 2. TELEPHONE

Home phone \_\_\_\_\_ Work Phone \_\_\_\_\_

Cell phone \_\_\_\_\_

Where do you prefer to receive your calls? Home Work Cell

What time of day is the best time to reach you? \_\_\_\_\_

In the event of an emergency, whom should we contact?

Name \_\_\_\_\_ Relationship \_\_\_\_\_ Phone # \_\_\_\_\_

## 3. CHIROPRACTIC INFORMATION

Describe your complaint.

How long have you had this condition? \_\_\_\_\_

Is it getting worse? \_\_\_\_\_

Have you seen a chiropractor before? If yes, how long ago?

\_\_\_\_\_

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Are you currently under the care of a physician? Yes \_\_\_ No \_\_\_

If yes, for what? \_\_\_\_\_

Physician's Name \_\_\_\_\_ Group: \_\_\_\_\_

Address \_\_\_\_\_

\_\_\_\_\_ Telephone # \_\_\_/\_\_\_/\_\_\_

#### 4. FINANCIAL ARRANGEMENTS

##### PAYMENT IS EXPECTED AT THE TIME OF EACH VISIT

Name of person responsible for payment:

\_\_\_\_\_

By signing this you understand that it is your responsibility to understand your medical insurance coverage fully. Co pays, coinsurance and deductibles are your responsibility to understand. In the event this office does assist in retrieving insurance information on your behalf is not a guarantee of payment. The patient (you) is responsible for any remaining balances not covered by your insurance company.

Print Name \_\_\_\_\_

Signature in compliance with above statement:

Are you insured? Yes No Company: \_\_\_\_\_

For your convenience, we offer the following methods of payment;

Cash Check Master Card Visa Disc Amex

#### 5. PRIMARY INSURANCE CARRIER INFORMATION

Insured's Name \_\_\_\_\_ Relationship \_\_\_\_\_

Birth Date \_\_\_\_\_ Soc. Sec.# \_\_\_\_\_

Employer \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Occupation \_\_\_\_\_

Type: Health \_\_\_ Medicare \_\_\_ Auto \_\_\_ Work Comp. \_\_\_ PPO \_\_\_ HMO \_\_\_

Group # \_\_\_\_\_ Policy# \_\_\_\_\_

Insurance Co. \_\_\_\_\_

Insurance Co. Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

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**SECONDARY INSURANCE**

Insured's Name \_\_\_\_\_ Relationship \_\_\_\_\_

Birth Date \_\_\_\_\_ Soc. Sec.# \_\_\_\_\_

Employer \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Occupation \_\_\_\_\_

Type: Health \_\_\_ Medicare \_\_\_ Auto \_\_\_ Work Comp. \_\_\_ PPO \_\_\_ HMO \_\_\_

Group # \_\_\_\_\_ Policy # \_\_\_\_\_

Insurance Co. \_\_\_\_\_

Insurance Co. Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

**Consent for Treatment of Minor**

I hereby authorize Dr. Michael A. Levinson, and whomever he may designate as his assistant(s), to perform diagnostic tests, including but not limited to, radiographs, and to administer treatment as he deems necessary to my child

\_\_\_\_\_  
Parent Signature \_\_\_\_\_ Date \_\_\_\_\_

**CONSENT FOR TREATMENT**

I, the undersigned, hereby authorize Dr. Michael A. Levinson and whomever he may designate as his assistants to perform diagnostic tests, including but not limited to radiographs, and to administer treatment as is necessary.

I, also, certify that no guarantee or assurance has been made to the results that may be obtained.

Patient/Parent Signature \_\_\_\_\_ Date \_\_\_\_\_

**AUTHORIZATION AND RELEASE**

I authorize Dr. Michael A. Levinson, to release any information including the diagnosis and records of any treatment or examination rendered to my child or me during the period of such care to a third party payer and/or other health practitioners. I authorize and request my insurance company to pay directly to Dr. Levinson insurance benefits otherwise payable to me. I understand that my insurance carrier may pay less than the actual bill for services rendered. I agree

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to be responsible for payment of all services rendered on my behalf or that of my dependents.

X \_\_\_\_\_ Date \_\_\_\_\_  
*Signature of patient or parent of minor*

**Authorization Release of Medical Information**

I \_\_\_\_\_, do hereby authorize you to release a copy of any and all information including x-rays, medical reports, clinical reports and other related documents acquired in the course of an examination and treatment.

Patient's Signature \_\_\_\_\_ Date \_\_\_\_\_