CLICK CHIROPRACTIC

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Patient Confidentiality Form

Patient Name:_____

Patient Date of Birth:_____

List the family members or other persons, if any, whom we may inform about your health and payment plans/history related to the care you receive.

Name:_____

Relationship:_____

Phone #:_____

Name:_____

Relationship:_____

Phone #:_____

_____ _____

Patients Signature **Date**

_____ _____

Parent or Guardian if under 18 **Date**