ANDOVER
spine & health
chiropractic wellness

PATIENT INFORMATION

PERSONAL INFORMATION

Full Name _____

Date of Birth _____ **Social Security #** _____ Male Female

Address _____

City _____ **State** _____ **Zip** _____

Phone Number _____ **E-Mail** _____

Marital Status Single Married Divorced Widowed

How did you hear about us? Social Media Internet Search Friend/Relative _____
Name of person who referred you

INSURANCE INFORMATION

Insurance Company _____ **Policy Holder** _____

Policy Number _____ **Policy Holder DOB** _____

EMERGENCY CONTACT

Name _____ **Relationship** _____ **Phone #** _____

REASON FOR YOUR VISIT

☐ General Wellness ☐ Slip/Fall ☐ Auto Accident ☐ Home Injury

☐ Pain ☐ Sports Injury ☐ Work Injury ☐ Other/Unknown

How long have you had this complaint: ☐ less than 5 days ☐ between 5-30 days ☐ more than 30 days

Brief description of fall/injury/accident:

INFORMED CONSENT TO TREATMENT

I certify that I'm the patient or legal guardian listed above. I have read/understand the included information and certify it to be true and accurate to the best of my knowledge. I consent to the collection and use of the above information to this office of chiropractic. I authorize this office and its staff to examine and treat my condition as the doctors see fit. I hereby authorize the doctor to release all information necessary to any insurance company, attorney, or adjuster for the purpose of claim reimbursement of charges incurred by me. I grant the use of my signed statement of authorization with my signature for required insurance submissions. I understand and agree that all services rendered to me will be charged to me, and I"m responsible for timely payment of such services. I understand and agree that health/accident insurance policies are an arrangement between an insurance carrier and myself. I understand that fees for professional services will become immediately due upon suspension or termination of my care or treatment.

Signature: _____ **Date:** _____

Andover Spine and Health Center
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