

Welcome to our office!

"We are all aware of how hard it is to live with neck or back pain.

***At our office we focus on finding and treating the root-cause of your pain
using natural gentle treatment. So, you feel better."***

Dr. Armaly, DC

PATIENT INFORMATION

Last name: _____ First name _____ Nickname _____

Date of Birth: _____ Sex: ____M ____F **Phone #:** _____

Street address: _____ City _____ State _____

Zip code: _____ **E-mail address:** _____

Who referred you to our office? _____

(No need to fill out the insurance information if you have your card with you!)

Insurance Name: _____ ID#: _____

Policyholder Name: _____ Policyholder Date of Birth: _____

HIPPA- Health Information and Accountability Act

I authorize the release of information including the diagnosis, records, examinations rendered to me and claims information. (Please fill in the names)

Spouse-Name_____ Phone:_____

Child(ren)-Name(s)_____ Phone:_____

Other-Name_____ Phone:_____

Information is not to be released to anyone other than for insurance purposes and when required by law. This Release of information will remain in effect until terminated by me in writing!

Do we have permission to communicate with you via; phone call, leave a message, text, email, or regular mail? Yes_____ No_____

Signed_____ Date: _____