NORTHWEST CHIROPRACTIC

Confidential Patient Information

The following information is needed in order to better serve you. Please complete all questions. If you need help please ask the receptionist. PLEASE PRINT

Today's Date ______________________ Cell Phone_____________

Name ____Female___ Male____Home Phone___________

Address____ City____________ State____ Zip__________

Age_____________________ Birthdate________________ Marital Status S M W D No. of Children_____________

Please circle one payment type: Cash Check Credit Card Flex Account Email Address: _____________________

Your Employer ___________________________________ Occupation ___________________ Years on Job _____

Employer Address __________________________________ City____________________ State____ Zip _________

Office Phone______________________________________ SS #_______________ Driv Lic # __________________

Insurance Company ____

Name of Spouse ____ Birthdate ______________________

Employer Address __________________________________ City____________________ State____ Zip _________

Spouse employed by ____ Occupation ____________ Years on Job _____

Office Phone______________________________________ SS #_______________ Driv Lic # __________________

Does your spouse have health Insurance at work Yes ___ No ___ Plan/Group # ________________________________

Describe the Major Complaints that bring you to our office ____

____

Is your condition due to an accident? Yes __ No __ Date of Accident ____

Type of accident? Auto ___ Work/On Job___ At Home___ Other ____

Have you ever been in an Auto Accident? Past Year _______ Past 5 years _______ Over 5 Years______ Never______

I (we) agree to pay for services rendered to the above mentioned patient as the charge is incurred. I understand and agree that health & accident insurance policies are an arrangement between an insurance carrier and myself and that I am personally responsible for payment of any and all services covered or non covered. I also understand that if I suspend or terminate my care and treatment, any fees for professional service rendered me will be immediately due and payable.
I, the undersigned, hereby authorize Dr. Kart and whomever she may designate as her assistant(s) 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's Signature____ Date __________________

Spouse or Guardian's Signature____ Date __________________

As a courtesy, we offer text message reminders would you like to Opt In _____________________ or Opt Out ______________________