Cruz Chiropractic

Chiropractic Case History/Patient Registration

Date: _____ Patient #: _____ Doctor: _____

Name: _____

Social Security #: _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____

E-Mail: _____

Age: _____ Birthdate: _____ Race: _____ Marital: M S W D

Occupation: _____ Employer: _____

Employer's Address: _____

City: _____ State: _____ Zip: _____

Office Phone: _____

Spouse: _____ Occupation: _____ Employer: _____

How many children?: _____ Names and Ages of Children: _____

_____

Name of Nearest Relative: _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____

How were you referred to our office?: _____

Family Medical Doctor: _____

When doctors work together it benefits you. May we have your permission to update your medical doctor regarding your care at this office?: Yes _____ No _____

Please circle any and all insurance coverage that may be applicable in this case:

Major Medical Worker's Compensation Medicaid Medicare Auto Accident

Medical Savings Account & Flex Plans Other _____

Name of Primary Insurance Company: _____

Name of Secondary Insurance Company (if any): _____

AUTHORIZATION AND RELEASE: I authorize payment of insurance benefits directly to the chiropractor or chiropractic office. I authorize the doctor to release all information necessary to communicate with personal physicians and other healthcare providers and payors and to secure the payment of benefits. I understand that I

am responsible for all costs of chiropractic care, regarles of insurance coverage. I also understand that if I suspend or terminate my schedule of care as determined by my treating doctor, any fees for professional services will be immediately due and payable.

The patient understands and agrees to allow this chiropractic office to use their Patient Health Information for the purpose of treatment, payment, healthcare operations, and coordination of care. We want you to know how your Patient Health Information is going to be used in this office and your rights concerning those records. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your Patient Health Information we encourage you to read the HIPAA NOTICE that is available to you at the front desk before signing this consent. The following person(s) have my permission to receive my Personal Health Information.

Patient's Signature: _____ Date:_____

Guardian's Signature Authorizing Care: _____ Date: _____