PATIENT DATA SHEET

PLEASE WRITE LEGIBLY

PERSONAL INFORMATION Date:_____

PATIENT NAME: _____
First Middle Initial Last

ADDRESS:_____APT#:_____

CITY:_____ STATE:_____ ZIP CODE:_____

HOME PHONE: (_____) _____ CELL: (_____) _____ WORK: (_____) _____
Circle your preferred contact phone number.

Would you prefer appointment reminders via text?

If yes, what cell phone carrier do you have (circle one)? AT&T Verizon T-Mobile Other:_____

EMAIL ADDRESS: _____

SOC SEC#:_____ DATE OF BIRTH:_____ AGE: _____ Gender: Male Female

OCCUPATION:_____ EMPLOYER:_____

REFERRED BY:_____

EMERGENCY CONTACT NAME: _____ RELATIONSHIP:_____ PHONE#: (_____)_____

RESPONSIBLE PARTY INFORMATION/NAME OF INSURED (IF SAME AS ABOVE, WRITE SAME AS ABOVE)

NAME: _ _____
First Middle Initial Last

ADDRESS:_____APT#:_____

CITY:_____ STATE:_____ ZIP CODE:_____

HOME PHONE: (_____) _____ CELL: (_____) _____ WORK: (_____) _____

SOC SEC#:_____ DATE OF BIRTH:_____ Gender: Male Female

OCCUPATION:_____ EMPLOYER:_____

CONSENT TO TREAT

I hearby authorize consent for **Cross Chiropractic Center** (Clinic) to provide medical care and treatment.

PRINT: _____ SIGN: _____ DATE:_____
Patient Patient

PRINT: _____ SIGN: _____ DATE:_____
Legal Guardian Legal Guardian

AUTHORIZATION & RELEASE

- I authorize the release of any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such care to third party payors and/or other health practitioners.
- I authorized and request my insurance company to pay directly to **Cross Chiropractic Center** (clinic), insurance benefits otherwise payable to me.
- I understand that my insurance carrier may pay less than the actual bill for medical services/supplies rendered. I agree to be responsible for payment on all medical services/supplies rendered on my behalf or my dependents

PRINT: _____ SIGN: _____ DATE:_____
Patient Patient

PRINT: _____ SIGN: _____ DATE:_____
Legal Guardian Legal Guardian