Confidential Patient Health Record **Date:** **ID No:**

Name: _____ Address: _____

City: _____ State: _____ ZIP/Postal Code_____

Home Phone: _____ Birth Date: _____ Age: ____ Sex: M F

Email:_____

Business Employer: _____ Circle one: Single Married

Address: _____ Occupation: _____

Business Phone: _____ Spouse's Employer: _____

Business Phone: _____ Occupation: _____

Referred to this office by: _____

Name and Phone # of Emergency Contact: _____

Relationship: _____

Who is responsible for your bill: you and Spouse/Work comp/Auto Ins./ Medicare

Personal Health Insurance (Name) _____ Health Card # _____

If Auto Accident: Insurance Company: _____

Address & Phone #: _____

Date of Accident: _____Time of Accident: _____

How Accident Occurred: _____

What Body Part Injured: _____

Current Complaints: _____

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that Van Chiropractic, P.C will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid shall be paid to Van Chiropractic, P.C. will be credited to my account on receipt. However, I clearly understand and agree that all services rendered to me are charged directly to me and I am personally responsible for payment. I the undersigned, patient at Van Chiropractic Clinic,P.C. authorize Van Chiropractic Clinic,P.C. to administer treatment as is necessary.

Patients Signature: _____ SS#: _____ Date: _____

Guardian or Spouse's Signature Authorizing Care: _____ Date: _____