Chiropractic Health Innovations
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____
Today's Date (MM/DD/YYYY)

____
Whom may we thank for referring you?

Gender
□ Male □ Female

Your Last Name ____________________

Your Social Security Number ____________________

Your First Name ____________________ **Your Middle Name (Or Initial)** ____________________ **Birth Date (MM/DD/YYYY)** ____________________ **Height** ____________________

Address ____________________

Marital Status
□ Single □ Married
□ Divorced
□ Widowed □ Separated

Weight ____________________

City ____________________ **State** ____________________ **ZIP/Postal Code** ____________________

Home Phone ____________________ **Cell Phone** ____________________ **Spouse's Name** ____________________ **Spouse's Birth Date** ____________________

E-Mail Address ____________________

Child's Name & Age ____________________

Emergency Contact ____________________ **Phone** ____________________

Child's Name & Age ____________________

Your Occupation ____________________ **Your Employer** ____________________

Child's Name & Age ____________________

Primary Physician ____________________

How can we help you today? ____________________

Acknowledgements

To set clear expectations, improve communications and help you get the best results in the shortest amount of time, please read each statement and initial your agreement.

Initials _____ **I have read and reviewed the Privacy Policy and understand it describes how my personal health information is protected and released on my behalf for seeking reimbursement from any involved third parties.**

Initials _____ **I grant permission to be called to confirm or reschedule an appointment and to be sent occasional cards, letters, emails, or health information to me as an extension of my care in the office.**

Initials _____ **I acknowledge that any insurance I may have is an agreement between the carrier and me and that I am responsible for the payment of any covered or non-covered services I receive.**

Initials _____ **I may request a copy of the Financial Policy at any time.**

To the best of my ability, the information I have supplied is complete and truthful. I have not misrepresented the presence, severity or cause of my health concern.

Signature ____________________ Date (MM/DD/YYYY) ____________________

If the patient is a minor child, print child's full name: ____________________

CONFIDENTIAL HEALTH INFORMATION