Welcome to Crystal Chiropractic

Patient Information

Today's Date: ____________________ Referred By:________________________________

Patient Name: ____

If patient is a child – please list any person who has permission to present your child for treatment: N/A____

Street Address: ____

City: ___________________________State: ________________Zip: __________________

Sex: Male Female **SSN: ______________________ DOB: __________________**

Marital Status: Minor Single Married Divorced Separated Widowed

Employer: ____

Email:(print)____

List the numbers in which Crystal Chiropractic can call and/or leave a message regarding appointments, Insurance coverage, or to return your call.

(Home)_________________ (Cell)_____________________ (Work)____________________

Who should we contact in the event of an emergency? ________________________________
Relation: _______________________________ Phone # ______________________________

Insurance Information: *If you are the insured, skip the next two lines.*

Insured's Name: ___________________________________ DOB: _____________________
SSN: _________________ Relation:__________________**Employer: __________________**

Your Protected Health Information will be used by Crystal Chiropractic or may be disclosed to others for the purpose of treatment, obtaining payment, or supporting the day-to-day health care operations of this office. By my signature below I give my permission to use and disclose my health information and that I have received a copy of the Notice of Patient Privacy Policy.

Print Name: ______________________ Sign Name: ________________________________
Date: ____________________________