Gilkey Family Chiropractic & Sports Injury Clinic

Dr. Chris A. Gilkey D.C., A.T.C

PATIENT INFORMATION

Date: _____ **First name**:_____ **MI**_____ **Last Name** _____ **SS#**:_____

Address: _____ **City:** _____ **State**:_____ **Zip**:_____

Home Phone:_____ **Mobile**:_____ **Marital Status**:_____ **Date of Birth**:_____

Sex: _____ **Email:** _____ **Emergency Contact**: _____# _____

Employer: _____ **Occupation**: _____ **Primary Care Physician**: _____

Spouse Name: _____ **Employer**: _____ **SS#**_____

Whom may we thank for referring you? _____

INSURANCE INFORMATION

Subscriber's Name:_____ Date of Birth_____ Address:_____

City: _____ State: _____ Zip: _____

Assignment and Release

I certify that I, and or my dependant(s), have insurance coverage and assign directly to Gilkey Chiropractic Clinic all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above-named doctor may use my health care information and may disclose such information to the insurance company (ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services.

_____ _____

(Signature of Patient, Parent, Guardian, or Personal Representative) **(Print name of Patient, Parent, Guardian, or Personal Representative)**

_____ _____

(Date) **(Relationship to Patient)**

ACCIDENT INFORMATION

Is this condition due to an accident? ▫ Yes ▫ No Date of accident_____ Type of accident ▫ Auto ▫ Work ▫ Home

To who have you made a report of your accident? ▫ Auto Insurance ▫ Employer ▫ Worker's Comp

CONSENT TO TREATMENT OF MINOR CHILD

I hereby authorize Dr. Gilkey and whomever he may designate as his assistants to administer chiropractic care as he deems necessary to my

son/daughter _____ (name of child)

Signed: _____ (name of parent) Witnessed: _____

Date: _____