GILKEYCHIROPRACTIC

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 Authorized Representative **Print name of Patient, Parent, Guardian, or Authorized Representative**

_____ _____

Date **Relationship to Patient**

PATIENT'S CONSENT

I understand that no guarantee or assurance has been made as to the results of this procedure and that it may not cure my condition. With my signature, I hereby consent to the performance of this procedure. I also consent to any measures necessary to correct complications which may result. I authorize qualified providers employed by Gilkey Chiropractic Clinic to treat me as clinically necessary.

_____ _____

Signature of Patient, Parent, Guardian, or Authorized Representative **Print name of Patient, Parent, Guardian, or Authorized 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) Date: _____

Signed: _____ (name of parent) Witnessed: _____