

PCC

**Palmetto Chiropractic
Clinic**

WELCOME

Optimum Health Through Chiropractic Care

Patient Information

Thank you for choosing our practice for your chiropractic needs. Please complete this form in ink. If you have any questions or concerns, do not hesitate to ask for assistance. We will be happy to help.

(Please Print)

Name _____ Date _____ SS# _____

Address _____
Last First MI City State Zip

Female Home Phone _____ Cell _____ Work _____
 Male

Birth Date _____ Age _____ E-Mail Address _____

Are you: Minor Single Married Separated Divorced Widowed

Employer _____ Occupation _____

Employer's Address _____

Spouse's or parent's name _____ Contact phone # _____

Children's names and ages _____

Whom may we thank for referring you to us? _____

Responsible Party

Name of person responsible for this account _____

Relationship to patient: Self Spouse Guardian Employer Other _____

Address _____

Phone # _____ Work # _____

Insurance Information

Name of Insured _____ Relationship to patient _____

Birth Date _____ SS# _____ Date employed _____

Employer _____ Work # _____

Employer Address _____

Insurance Company _____ Phone # _____

Insurance Co. Address _____

Have you met your annual deductible yet? Yes No

Do you have additional insurance? Yes No If so, please provide additional information.

I certify that I have read and understand the above information to the best of my knowledge. The enclosed questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the chiropractor to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such chiropractic care to third party payers and/or health practioners. I authorize and request my insurance company to pay directly to the chiropractor or chiropractic group insurance benefits otherwise payable to me, I understand that my chiropractic insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all service rendered on my behalf or my dependents. I the undersigned, a patient in this office do hereby authorize Dr. Alden and whomever he may designate as his assistants to administer treatment as necessary. I also understand that no guarantee or assurance has been made in the results that may be obtained.

Patient's Signature _____ **Date** _____