Patient Name: _____ Date: _____

Address: _____ City: _____ State: _____

Zip: _____ Phone: _____ Hm, Wk, Cell

Email: _____ Date of Birth: _____/_____/_____ Age: _____

Smoking status: former / current / never Sex: M F Marital: M S D W

Emergency Contact (Name & Phone #): _____

How did you hear about us? _____

Primary Care Doctor: _____

Acknowledgments

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

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 this office.

Initials _____ I understand that any insurance I may have is an agreement between the carrier and myself 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.

Initials _____ (FEMALES ONLY) I realize that an X-ray examination may be hazardous to an unborn child and I certify that to the best of my knowledge I am not pregnant

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 problem.

Signature: _____ Date: _____