

Patient Information Sheet

SSN _____ Last Name _____ First Name _____ MI _____

Gender ___ M ___ F D. O. B. ___/___/___ Marital Status ___ S ___ M ___ D ___ W

How did you hear about our office? _____

Address _____ City _____ State _____ Zip _____

Home Phone _____ Cell Phone _____ Email _____

Language ___ English ___ Spanish ___ Other: _____

Employer Name _____ Address _____

Work Phone _____ Employment Status ___ Full ___ Part ___ Retired ___ Disabled

Emergency Contact Information:

Name _____ Phone _____ Relationship _____

Primary Insurance

Secondary Insurance

Insurance: _____

Insurance _____

Policy Number _____

Policy Number _____

Group Number _____

Group Number _____

Insured Name* _____

Insured Name* _____

Relation to Patient _____

Relation to Patient _____

Insured D.O.B.* _____

Insured D.O.B.* _____

*If your insurance is in another family member's name the above fields would be that family member's information

RELEASE OF INFORMATION AND PATIENT CONSENT

I authorize Sitzmann Chiropractic LLC to release any information acquired in the course of my medical examination and treatment. I authorize all information to be released to my insurance company, third party payers, case utilization, managed care review companies, Health Care Financing Administration. I further authorize information to be released to all other Sitzmann Chiropractic LLC affiliated institutions or individuals who will be providing healthcare services to me.

I hereby authorize Sitzmann Chiropractic's staff to give the following people information concerning my test results, health status, appointment times, and procedure information. Name _____

FINANCIAL AGREEMENT

INSURANCE: I understand and agree that health insurance policies are an arrangement between my insurance carrier and myself. I understand that Sitzmann Chiropractic will file all primary insurance claims for me. I authorize payment of medical benefits directly to Sitzmann Chiropractic, LLC. Furthermore, I agree that if my insurance does not pay for my claim(s), it will become my responsibility.

SELF PAY: We request full payment at the time treatment was rendered. To financially assist you and your family members, we offer pre-pay, wellness, student, and child plans. We are happy to accept cash, check, or credit card.

**Name _____ Signature(Guardian) _____ Date _____