Welcome

ABOUT YOU

Today's Date:____/____/_____ File #:_____

Name: _____

What You Prefer To Be Called:_____

[ ] Male [ ] Female

Birthdate:____/____/____ Age:____ SS#:_____-_____-_____

Mailing Address:_____

City:_____

State:_____ Zip:_____

Home Ph#:_____ Work Ph#:_____

Mobile Ph#:_____ Fax Ph#:_____

E-mail Address:_____

Referred By:_____

Employer:_____

Employer Address:_____

City:_____ State:_____ Zip:_____

Occupation:_____

Marital Status: [ ] Single [ ] Married [ ] Divorced [ ] Separated [ ] Widowed

Spouse's Name:_____

MINOR CONSENT

I hereby authorize Odessa Chiropractic Center and it's doctor(s) to administer chiropractic care as deemed necessary to my (circle one)

son / daughter / ward

Signed:_____

Date:_____

IN EVENT OF EMERGENCY

Contact:_____

Relation:_____

Their Home Ph#:_____

Their Work Ph#:_____

Your Medical Doctor?

_____

Ph#:_____

Person Ultimately Responsible For Account

Name:_____

Relation:_____

Billing Address:_____

City:_____ State:_____ Zip:_____

SS#:_____

DL#:_____

Work Ph#:_____

Payment Method: [ ] Cash [ ] Check [ ] Credit Card

[ ] I hereby authorize assignment of my insurance rights and benefits directly to the provider for services rendered. (if Co. is accepted by this office)

INSURANCE INFORMATION

Co. Name:_____

Address:_____

_____

Ph.#:_____

Insured's SS#:_____

Group/Policy#:_____

Insured's Name:_____

Relation:_____ Date of Birth:_____

Insured's Employer:_____

PLEASE GIVE INSURANCE CARD AND DRIVERS LICENSE TO FRONT DESK TO BE COPIED.

I understand and agree that all services rendered me are charges directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered me will be immediately due and payable. I authorize this office to perform any necessary services needed during diagnosis and treatment. It is understood and agreed the amount paid the Doctor, for x-rays, is for examination only and the x-ray negatives will remain the property of this office. The patient also agrees that he/she is responsible for all bills incurred at this office and if account is not paid within 90 days of the date of service I will be responsible for any legal fees, collection agency fees, or any other expenses incurred in collecting your account.

Patient Signature _____ Date _____

Guardian or Spouse's
Signature Authorizing Care _____ Date _____

TERMS OF ACCEPTANCE

When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for both to be working towards the same objective.

Chiropractic has only one goal. It is important that each patient understand both the objective and the method that will be used to attain it. This will prevent any confusion or disappointment.

Vertebral Subluxation: A misalignment of one or more of the 24 vertebra in the spinal column which causes alteration of nerve function and interference to the transmission of mental impulses, resulting in a lessening of the body's innate ability to express its maximum health potential.

Adjustment: An adjustment is the specific application of forces to facilitate the body's correction of vertebral subluxation. Our chiropractic method of correction is by specific adjustments of the spine.

Health: A state of optimal physical, mental and social well-being, not merely the absence of disease or infirmity.

We do not offer to diagnose or treat any disease or condition other than vertebral subluxation. However, if during the course of a chiropractic spinal examination, we encounter non-chiropractic or unusual findings, we will advise you. If you desire advice, diagnosis or treatment for those findings, we will recommend that you seek the services of a health care provider who specializes in that area.

Regardless of what the disease is called , we do not offer to treat it. Nor do we offer advise regarding treatment prescribed by others. OUR ONLY PRACTICE OBJECTIVE is to eliminate interference to the expression of the body's innate wisdom. Our only method is specific adjusting to correct vertebral subluxations.

I, _____ have read and fully understand the above statements.
(Print Name)

I therefore accept chiropractic care on this basis.

_____ _____
(Sign) (Date)