PATIENT INFORMATION AND CONSENT FOR TREATMENT

Date_____

Name _____ Soc. Sec. # _____ Home Phone _____

Address _____City _____ State_____ Zip _____

Age _____ Birth Date / / Sex _____ Driver's License #_____ Marital Status M S W D

No. Children _____ Occupation _____ Employer _____

Business Address _____Business Phone _____

Name of Insurance Co. _____ Policy # _____ Group # _____

Name of Insured _____ Birth Date _____ Sex ____ Relationship to Patient _____

Insured's Place of employment _____ Insured's Social Security Number _____

Secondary Insurance Co. _____ Policy # _____ Group # _____

Name of Insured _____Birth Date _____Sex_____ Relationship to Patient_____

Insured's Place of employment _____ Insured's Social Security Number _____

Name of Spouse _____ Occupation _____

Spouse's Employer _____ Business Address _____ Phone _____

Name of person to contact in case of emergency _____ Phone _____

Name of nearest blood relative not living with you _____ Phone _____

How did you hear about West Bay Chiropractic? Name _____Other_____

Name of person responsible for payment _____

I understand that insurance policies are an arrangement between the insurance carrier and myself. Any disputes with my insurance carrier regarding payment of a claim will be settled between me and the carrier. I hereby authorize West Bay Chiropractic Center to release information to my insurance carrier and further authorize insurance payments to be paid directly to West Bay Chiropractic Center.
I understand and agree that I am personally responsible for payment for all services rendered.
I understand that interest charges will accrue monthly on all unpaid balances and that I am responsible for payment of all collection fees should my account become delinquent.

Responsible Party Signature _____ Date _____

CONSENT FOR TREATMENT

I hereby authorize chiropractic care to be rendered by West Bay Chiropractic Center. This authorization for treatment is for myself (Name) _____ or for (Name) _____ of whom I am the parent or legal guardian. I understand that no guarantee as to results has been made to me, and I wish to rely on the Doctor to exercise judgment as to my best interest during the course of my treatment.

Patient Signature _____Parent or Legal Guardian _____