

**HATFIELD CHIROPRACTIC & REHAB CENTER
PATIENT INFORMATION**

(Please Print Clearly)

First: _____ MI: _____ Last: _____ Preferred Name: _____

Mailing Address: _____ City/State/ZIP: _____

Physical Address (if different): _____ City/State/ZIP: _____

Home Phone: _____ Cell Phone: _____ E-mail Address: _____

Used to contact you in relation to your care unless otherwise authorized.

Whom may we thank for referring you? _____ Preferred Language: _____

Male Female Date of Birth: _____ Age: _____ SSN: _____

Single Married Divorced Widowed Spouse: _____ # of children _____

Employment Status: Full-time Part-time Student Unemployed Retired (Date) _____

Occupation: _____ Work duties: _____

Employer/School: _____ Phone: _____

Employer/School Address: _____ City/State/ZIP: _____

May we contact you at work? Yes No Preferred method of contact? Home Phone Cell Phone Work Phone Email

PERSON TO NOTIFY IN CASE OF EMERGENCY (Friend or Relative NOT at your address):

Name: _____ Relationship: _____ Phone: _____

Address: _____ City/State/ZIP: _____

Primary Physician _____ Address _____ Phone _____ Last exam _____

DO YOU HAVE INSURANCE? Yes No

ARE YOU ELIGIBLE FOR MEDICARE? Yes No Aged 65 Disabled End Stage Renal Disease Other _____

MEDICARE ONLY

Original MEDICARE # (Please present Medicare Card): _____

Do you or your spouse work for a company that provides you with health insurance? No Yes

Insurance (Please present I.D. Card): _____ Group #: _____ I.D. #: _____ Phone: _____

Insured Name: _____ DOB: _____ SSN: _____ Relationship _____

Address: _____ City/State/ZIP: _____ Phone: _____

Employer: _____ Occupation _____

Address: _____ City/State/ZIP _____ Phone: _____

Do you have a Medicare Supplement policy? No Yes

Insurance (Please present I.D. Card): _____ Group #: _____ I.D. #: _____ Phone: _____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES:

I acknowledge that I have had the opportunity to review and request a copy of the HIPAA Notice of Privacy Practices. In addition to those described in the Privacy Policy, **I give permission to Hatfield Chiropractic to discuss my health care and billing information with the following person(s) until I revoke such in writing:**

Name _____ Relationship _____

Name _____ Relationship _____

Name _____ Relationship _____

AUTHORIZATION AGREEMENT AND NOTIFICATION STATEMENT:

I certify that I am the patient or legal guardian of the patient. The information is true and accurate to the best of my knowledge and I consent to its collection and use by **Hatfield Chiropractic**. I understand that health and accident insurance policies are an arrangement between my insurance carrier and me. I authorize **Hatfield Chiropractic** to release all information necessary for my treatment, payment, or healthcare operations. I authorize payments to be made directly to **Hatfield Chiropractic**. If I change insurance companies or attorneys during my treatment, I am obligated to inform **Hatfield Chiropractic** immediately. I understand that I am ultimately responsible for all balances due and that payment is expected at time of service.

Patient Signature (Parent/Legal Guardian if patient is a minor)

Date

Name of Parent/Legal Guardian (print)

Relationship to Patient