HATFIELD CHIROPRACTIC & REHAB CENTER
PATIENT INFORMATION

(Please Print Clearly and Complete ENTIRE Form)

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

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

Reason(s) you are eligible for Medicare: ❑Aged 65 ❑Disabled ❑End Stage Renal Disease ❑Other _____

TYPE OF MEDICARE: ❑ Original ❑ Advantage Plan/Part C (Aetna Medicare, AARP Medicare, BCBS Medicare, Humana Gold, etc.)

ORIGINAL MEDICARE PATIENTS – COMPLETE THIS SECTION

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.

Date _____

_____
Name of Parent/Legal Guardian (print)

_____
PATIENT SIGNATURE (Parent/Legal Guardian if patient is a minor)

Relationship to Patient_____