



ENTRANCE APPLICATION

Welcome! We are honored that you chose us to evaluate your condition, you will not be disappointed! In order for us to better serve you and file your insurance forms for you, please fill out the form below completely. If you need any assistance please feel free to ask our front desk staff. Thank you for taking the time to fill this out.

Name: _____ **Date:** _____ **Acct#:** _____

Address: _____ **City/State:** _____ **Zip:** _____

Birth Date: _____ **Age:** _____ **Sex:** M F **Height:** _____ **Weight:** _____

Marital Status: S M D W **Spouse's Name:** _____ **# of Children:** _____

Social Security #: _____ - _____ - _____ **Drivers License #:** _____

Home Phone #: _____ **Cell #:** _____ **Work #:** _____

E-Mail Address: _____ **Insurance?** Y N

Occupation: _____ **Employer:** _____

Name of person on your health insurance Card _____

Their DOB _____ **Their SSN#** _____ - _____ - _____ **Their Phone#:** _____

Name of their employer _____ **City** _____ **Employer Phone#** _____

Children--Names & Ages _____

In case of emergency, whom should we contact? _____

Relationship: _____ **Phone#:** _____

FAMILY PHYSICIAN _____ **Phone#:** _____

What is your primary complaint? _____

How did you hear about our office? _____

IS THIS WORKMAN'S COMPENSATION? **IS THIS AN AUTO ACCIDENT?**

Patient Informed Consent

I _____ the undersigned patient, consent to the treatment(s) provided by this clinic. I understand that my condition may necessitate modifications from time to time of the type of treatment(s) rendered and the portions of my body that may need to be examined. I understand and consent to clinic staff providing me with verbal descriptions, when there are changes to my exam(s) and treatment(s), consent to the clinic staff providing said treatment(s) and exam(s) and hereby consent to any similar subsequent treatment(s) or exam(s). If I do not consent, I will immediately inform clinic staff. There are times when individuals other than staff may see me receive treatment at the clinic or overhear discussions of my condition or insurance, I consent to others perceiving these interactions at the clinic. If additional privacy is required, I will inform the clinic staff.

Patient Signature