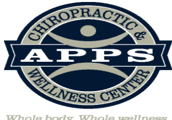

Patient Intake Form

Patient Information:

Name: ____ Date: ______________________

SS#: _______________________________________ Date of Birth: ___/_____/____ Age: ______

Address: _____________________________________ City: ___________ State: ____ Zip: _____

Sex: __Male ___Female __Married __Widowed __Single __Divorced __Minor

Home: (___) ____-_____ Cell: (___) ____-_____ Cell phone Carrier:___________________

Emergency contact: __________________Relationship: ___________Phone: (___) ____-_____

Email address: __________________________

Send Appointment reminders: Email ______ or Text ______

Patient in School: ___Yes ___No School: ____

Patient Employed: ___Yes ___No Occupation: ______________________________________

Employer: ________________________ Address: _____________________ Phone: ___________

Spouse's Name: ________________________Date of Birth: ___/_____/____ SS#: _________ ___

Employer: ________________________ Address: _____________________ Phone: ___________

Insurance Information:

Primary Insurance Company: _______________ Policy#: _______________ Group#: ________

Policy Holder: ____________________ Date of Birth: ___/___/____ Relation to patient: _______

Secondary Insurance Company: _________________ Policy#: _____________ Group#: _______

Policy Holder: ____________________ Date of Birth: ___/___/____ Relation to patient: _______

Assignment and Release

I certify that I, and/or my dependant(s), have insurance coverage with _____________ (Insurance company name) and assign directly to Apps Chiropractic and Wellness Center all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.
The above-named clinic may use my health care information and may disclose such information to the above-named Insurance company/ies and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for the related services. This consent will end one year from the signed below.

____ ___________________________________
Signature of Patient, Guardian or Personal Representative Date

____ ___________________________________
Please print name of Patient, Guardian or Personal Representative Date

Accident Information:

Is your visit today due to a condition from a result of an accident? ___No ___Yes

Date of Accident: ___/___/____ Type of Accident: ___Work ___Auto ___Home ___Other ___________

To who have you made a report of your accident? ____ Employer ____Auto Insurance

____Worker Comp. ____Other ____________

Attorney Name (if applicable): ________________________________ Phone: ______________________

Informed Patient Consent:

I understand that if I am accepted as a patient of William E.S. Apps, DC, I am authorizing the doctor to proceed with further treatment that may be necessary. Furthermore, any risks involving chiropractic treatment will be explained to me upon request.

____________________________ ______________________________ _______________________
Patient Name Patient Signature Date

____________________________ ______________________________ _______________________
Parent/Guardian Name Parent/Guardian Signature Date