ARCTIC CHIROPRACTIC NOME

Patient Intake
CONFIDENTIAL PATIENT INFORMATION

Personal

First Name ________________________ MI __________ Last Name ____________________________ Nickname ______________

Mailing Address__________________________________ City____________________ State ___________ Zip ________________

Cell Phone __________________________ Home Phone __________________________ Work Phone ________________________

Birthdate _______/_______/_______ SSN _________________________________ Sex M / F Marital Status _______________

Email Address ____

Occupation ____ Employer ___________________________________

Who may we thank for referring you to our office or how did you hear about us? ____

Guardian/Spouse Information

Guardian/Spouse Full Name __________________________________ Birthdate _______/_______/_______

Guardian/Spouse Employer ___________________________________ Work Phone __________________________

Insurance

Please submit a photo ID and your insurance cards so that we may copy them to your file.

Is your visit due to an: Auto Accident ________ On-The Job Accident ________ (Please check if either applies)

Current Health Information

Purpose of this Appointment____

Briefly describe your symptoms ____

When did this condition begin? ___________________ Has this condition occurred before? When? _________________________

Have you had X-rays, MRI or other imaging for this condition in the past? ☐Yes ☐ No

List other doctors seen for this condition ____

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that this office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to this office will be credited to my account upon receipt. I permit this office to endorse co-issued remittances for the conveyance of credit to my account, however, I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. It is my understanding that my credit may be check if Arctic Chiropractic Nome extends credit to me and I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered to me will be immediately due and payable unless prior arrangements are made. I hereby authorize the doctors at Arctic Chiropractic Nome and whomever they may designate as their assistants to administer treatment as they so deem necessary and I also authorize the release of any information acquired in the course of my examination and/or treatment. I certify that the above information is true and correct.

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PATIENT (PARENT/GUARDIAN) SIGNATURE DATE