Confidential Patient Information

Date: _____/_____/_____

Patient's Full Name: _____ Date of Birth: _____/_____/_____

Mailing Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Social Security #: _____ - _____ - _____ ☐ Male ☐ Female Spouse's Name: _____

☐ Married ☐ Single ☐ Widowed ☐ Divorced Referred by (Friend, Relative, Physician or Other): _____

Status: ☐ Employed ☐ Unemployed ☐ Student ☐ Retired Occupation: _____

Employer: _____ Employer Address: _____

Emergency Contact: _____ Relationship: _____ Phone: _____

Primary Insurance Company: _____ ID#: _____ Group#: _____

Insured's Name: _____ Date of Birth: ____/____/_____ Employer: _____ Relation to Insured: _____

Secondary Insurance Company: _____ ID#: _____ Group#: _____

Insured's Name: _____ Date of Birth: ____/____/_____ Employer: _____ Relation to Insured: _____

Family Physician: _____ City: _____ State:_____ Phone: _____

Previous Chiropractic Care: ☐ Yes ☐ No If Yes, for what Problem: _____

Doctor's Name: _____ City: _____ State: _____

What type of care are you interested in: ☐ Pain relief only ☐ Healing of current condition ☐ Optimizing your health ☐ All three

What is your long-term goal from treatment (e.g. play a round of golf without pain)?: _____

Your education level: ☐ Highschool ☐ Some college ☐ College Graduate ☐ Post Graduate ☐ Other: _____

If **YES** to either questions below, please check with receptionist, additional information is needed.

Is Today's Visit Due To A Work Related Injury: ☐ Yes ☐ No Date of Injury: _____

Employer at Time of Injury: _____ Phone# _____ Claim# _____

Is Today's Visit Due To An Auto Accident: ☐ Yes ☐ No Date Of Injury: _____

Have you Hired an Attorney? □ Yes □ No Attorneys' Name: _____ Phone#: _____

Authorization and Assignment

In consideration of your undertaking to care for me, I agree to the following:

1. You are authorized to release **any information** you deem appropriate concerning my physical or emotional condition, health history, or billing and payment history to any insurance company, attorney, or adjuster for the purpose of any claim for reimbursement of charges incurred by me.
2. I authorize my attorney and/or any insurance company to make **direct payment to you** of settlement proceeds.
3. I hereby assign and transfer to you the cause of action that exists in my favor against any insurance company obligated by contractual agreement to make payment to me or to you for the charges made for your service. I authorize you to prosecute said action either in my name. I further authorize you to compromise, settle, or otherwise resolve said claim as you see fit. I under-stand that whatever amounts you do not collect from insurance companies, whether it be all or part of what was due, **I personally owe to you**.
4. I further agree that this Authorization and Assignment is irrevocable until all moneys owed to you (Logan C. Martin PC) are **paid in full**.

Patient Signature: _____ Date: _____