*deBarros Chiropractic Clinic*
*7020 Cold Harbor Rd.*
*Mechanicsville, VA 23111*

## PATIENT INFORMATION

**PATIENT NAME**
Last Name _____ First Name _____ Middle _____
Date of Birth: _____ Social Security #: _____-_____-_____
Home Address _____ Apt #_____
City _____ State _____ Zip_____
Home Phone # _____Work Phone #_____
Cell Phone# _____ Email Address: _____
Preferred Communication _____ Shoe Size: _____
Gender: M F Marital Status: S M D W Smoker? Y N Ethnicity: _____
Primary Insurance Company: _____ Occupation: _____

**SPOUSE or GUARDIAN**
Last Name _____ First Name _____ Middle _____
Employer Name _____ Work Phone # _____
Date of Birth ____ / ____ / ____ SS# _____

**EMERGENCY** Name and address of nearest relative or friend not living with you.
Last Name _____ First Name _____ Middle_____
Home Phone # _____ Work Phone # _____
Relation to Patient _____

**PAYMENT METHOD** For all services that are not paid by a third party.

**□ Cash □ Check □ Visa □ MasterCard □ Discover □ American Express**

If you have any insurance coverage that might pay a portion of your financial obligations, please ask about our policy.

### My Certification

I certify that the above information is correct and I request services.

x _____ _____
Signature of patient or person acting on patient's behalf Date

### MY Privacy

I have received a copy of the **Notice of Privacy Practices.** I understand that I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to: Conduct, plan and direct my treatment and follow-up among the healthcare providers who may be directly and indirectly involved in providing my treatment; Obtain payment from third-party payers'; Conduct normal healthcare operations such as quality assessments and accreditation.

x _____ _____
Signature of patient or person acting on patient's behalf Date