CONFIDENTIAL INFORMATION REPORT

CHAMBLEE CHIROPRACTIC CENTER, P.C.

(OFFICE USE ONLY)
ACCOUNT ID: ________________ FIRST TREATMENT: ____________________________
DIAGNOSIS: __________/__________/__________/__________/__________

PERSONAL INFORMATION:
PATIENT NAME: ______________________TODAY'S DATE __________
HOME ADDRESS: ____
CITY/STATE/ZIP: ____________________________________
CELL TEL :( )________________WORK TEL :( )________________
EMAIL ADDRESS: ____________________________________
DOB: _______________AGE ________SEX: _____M _____F
SOC.SEC. NO: ________________________ MARITAL STATUS: _____ S _____M _____D _____W
EMPLOYER: ____________________ OCCUPATION: _____________
IN CASE OF AN EMERGENCY NOTIFY: __________________ TEL: ( )______________
RELATIONSHIP: ______________________ HOW DID YOU HEAR ABOUT OUR OFFICE?: _____
AD ____WALK-IN ____PATIENT____OTHER

GENERAL INFORMATION:
DATE OF INJURY/ILLNESS: ________________ TYPE OF INJURY: _____
AUTO _____SPORT _____OTHER
DID YOU GO TO THE HOSPITAL?: _____NO _____YES IF YES, WHICH
ONE?:__________________________ DOCTOR NAME: _________________
PHONE: ( ) ________________CURRENT SYMPTOMS: ________________________

INSURANCE INFORMATION:
INSURANCE CARRIER____________________________PHONE: ( ) ______________
POLICY#: _______________ CLAIM # _______________ MED PAY: ______
YES ______NO_______

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I CERTIFY THAT I HAVE READ AND UNDERSTAND THE ABOVE INFORMATION TO THE BEST OF MY KNOWLEDGE. THE FOLLOWING QUESTIONS HAVE BEEN ANSWERED TO THE BEST OF MY KNOWLEDGE, AND I UNDERSTAND THAT PROVIDING INCORRECT INFORMATION CAN BE DANGEROUS TO MY HEALTH. I HEREBY AUTHORIZE RELEASE OF MY MEDICAL RECORDS TO CHAMBLEE CHIROPRACTIC CENTER, P.C. WE WILL FILL OUT ALL INSURACE FORMS FOR YOUR CLAIM. YOU ARE RESPONSIBLE FOR YOUR BILL IN THE EVENT OF DELINQUENCY AND ALL COLLECTION COST WHICH INCLUDE (BUT NOT EXCLUSIVE TO) ATTORNEY FEES, COURT COSTS, AND ACCUMULATED INTEREST OF 1.5% WILL BE ADDED TO THE TOTAL BALANCE OF YOUR MEDICAL BILLS MONTHLY.

SIGNATURE: ______________________________________DATE: ______________
(PATIENT, PARENT OR GUARDIAN)