CONFIDENTIAL HEALTH INFORMATION

General Info:

Patient Name:_____ Middle Init:_____ Last Name:_____
Address:_____ City, State, Zip:_____
Home Phone:_____ Cell Phone:_____
Date of Birth:_____ Social Security;_____
E-mail:_____
Preferred Method of Contact: □Home □Cell □Work
Sex: □Male □Female Martial Status: □Single □Married □Divorced □Widowed
Emergency Contact:_____ Phone:_____
Employer:_____ Phone:_____
Address:_____ City, State, Zip:_____
Insurance Carrier:_____ Insurance ID#:_____
Relationship to Insured: □Self □Spouse □Child □Parent
If not Self Insured Name:_____
Insured Date of Birth:_____ Insured Social Security:_____
Who may have access to patient's medical records?_____

Acknowledgements:

I may request a copy of the Privacy Policy and understands that it describes how my personal health information is protected and released on my behalf for seeking reimbursement from any third parties_____ Init
I acknowledge that any insurance I may have is an agreement between the carrier and myself and that I am responsible for any covered or non-covered services that I receive_____ Init
I consent to exams, x-rays and therapies that the chiropractor deems necessary_____ Init
If patient is a minor child I_____ (parent/guardian) give permission for _____ to receive exams, x-rays and any therapies that the doctor deems necessary_____ Init
I authorize and require that _____ release any and all medical records to Wheeler Health Group, PC _____ Init
MEDICARE PATIENTS ONLY: I am aware that Medicare does not pay for exams, therapies, or x-rays and these charges are my responsibility _____ Init

To the best of my ability, the information I have supplied is complete and truthful as of _____
(today's date)

_____ _____
(Parent's Signature if a minor child) Patient's Signature

For Office Use Only
*Insurance Deductible*_____ *Unused Deductible* _____ *Max Visit*_____
*Patient Percentage*_____ *Maximum Charge*_____
If Medicare Supp: Pays Medicare Deductible |*Yes* |*No*