

Placentia Linda Chiropractic
1050 E. Yorba Linda Blvd. Unit104
Placentia, CA, 92870
(714) 223-5920

Date_____

Please Print

PATIENT INFORMATION

Name_____

Address_____

City_____ Zip_____

Birth Date_____ Sex M F

Home Phone#_____

Cell Phone#_____

Social Security#_____

Driver License#_____

Marital Status_____

Email address_____

Referred By_____

EMPLOYER INFORMATION

Occupation_____

Employer_____

Employer Address_____

City_____ Zip_____

Business Phone#_____ ext._____

REASON FOR CONSULTATION

What are your present complaints and symptoms?

Is your condition a result of a: Work injury?_____

Auto accident?_____

Other_____

Date of injury or onset_____

Family Physician_____

Phone#_____

AUTHORIZATION TO PAY BENEFITS TO PHYSICIAN

I hereby authorize payment of benefits be made directly to this healthcare provider and I understand that I am responsible for charges not covered by this assignment. I also authorize the release of any information requested to process this claim

Signed_____

(Insured Person)

Date_____

CONSENT TO TREATMENT OF A MINOR

I (we) being the parent/guardian of the above patient, a minor, the age of _____, do hereby consent, authorize and request Placentia Linda Chiropractic and whomever they man designate, to administer such treatment deemed advisable, necessary or requested for this minor.

Signed_____

(Parent or Legal Guardian)

Date_____

RESPONSIBLE PARTY INFORMATION

(if other than self)

Name_____

Relationship to Patient_____

Social Security#_____ DOB_____

Home Phone#_____

Cell Phone#_____

Work Phone#_____

Address_____

City_____ Zip_____

Employer's Name_____

Address_____

City_____ Zip_____

Occupation_____

If patient is a child, name of other parent

Address_____

City_____ Zip_____

Home Phone#_____

Work#_____

INSURANCE INFORMATION

Are you insured? Y N

(Please present insurance card to receptionist)

Insurance company_____

Other Insurance company_____

EMERGENCY CONTACT

Name_____

Relationship_____

Phone#_____