Eric Waltemate, D.C.

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PATIENT INFORMATION

SELF

Last Name _____

First Name _____ MI _____

Street _____

City _____ State _____

Zip _____

E-Mail _____

Home Phone _____ Cell _____

SPOUSE/PARENT ***(fill out if minor or Insurance in under your spouses name)***

Last Name_____

First Name _____ MI ____

Street _____

City _____ State _____

Zip _____

E-Mail _____

Home Phone _____ Cell _____

Preferred Means of Communication: □ Phone □ Mail □ Email □ Other: _____

Birth Date _____ Age _____ Sex ____

Social Security #_____

Birth Date _____ Age _____ Sex ____

Social Security # _____

Student ___Married ___Single ___Separated ___Divorced ___Widowed ___

Employer: _____ Employer Phone: _____

Primary Doctor's Name _____ Phone _____

In case of an emergency who do we call? Name_____ Phone_____

How did you find out about our office: _____

Describe the major complaint that brings you to our office:_____

_____

Is your condition due to an accident? □Yes □No Date of your accident: _____

PATIENT CONSENT & SIGNATURE

By my signature below, I acknowledge that I have read or have had read to me and have received a photocopy upon my request of this document including the Healthcare Privacy Notice, Informed Consent, Assignment of Benefits—Authorization & Lien, Insurance Benefits—Credit Policies—Payment Terms & Conditions, and fully understand and have had all of my questions answered to my satisfaction. A photocopy of this document shall be considered as effective and valid as an original. I give this office the right to use my name for any in-office publications, mailings, or newsletters. Authorization may be denied or retracted by notifying the office manager. I (we) consent to updates and marketing sent by e-mail, letters, phone, etc. I (we) authorize the doctor and his staff to release or request any information deemed appropriate concerning my physical condition to any insurance company, claims adjuster, case nurse, claims reviewer, employer, heath care provider or attorney in order to process any claim for reimbursement or charges incurred by me as a result of professional services rendered and hereby release the doctor of any consequences thereof or to continue or provide necessary information to assist in the treatment or management of my case or condition. My signature serves as receipt of "signature on file". If the above patient is a MINOR: I (we) being the parent, legal guardian or custodian shown above, do hereby authorize, request and direct the Facility and staff to perform examinations, diagnostic tests, and any treatment that in their judgment, is deemed advisable to required. It is the understanding of the undersigned that the Licensed Healthcare Provider and their staff will have full authority from me as a legal parent/guardian to continue with examinations, diagnostic tests and treatment as will be needed while said minor shown above is under care in the Facility until legal age is attained. I (we) acknowledge that it is the policy of this office to collect all fees for the first visit up front to cover charges that may not be covered by my (our) insurance, assuming I (we) have insurance coverage for services rendered at this office. If no insurance coverage is available, I agree to pay for all services rendered at the time of service unless a previous arrangement has been made. I (we) also agree to pay a $25 missed appointment fee if I (we) do not give 24 hours notice before missing an appointment.

_____

Signature (if minor, parent, legal guardian, or Custodian must sign) Date