



# Welcome to Allied Chiropractic

Date \_\_\_ / \_\_\_ / \_\_\_

Name: \_\_\_\_\_ Address: \_\_\_\_\_ Apt# \_\_\_\_\_  
Social Security Number: \_\_\_\_\_ City: \_\_\_\_\_  
Birthdate: \_\_\_\_\_ Age: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_  
Cell Phone: \_\_\_\_\_

Is this auto or work related? \_\_\_\_\_

Do you have insurance that you would like to use in our clinic? \_\_\_\_\_

**POLICY HOLDER'S DATE OF BIRTH:** \_\_\_\_\_

Have you had x-rays or other tests for this problem in the past 8 months? \_\_\_\_\_

Confirm appointment time and date. \_\_\_\_\_

**Insurance Information:** Company Name \_\_\_\_\_,

Phone Number: \_\_\_\_\_ Policy #/ ID #: \_\_\_\_\_,

Group #: \_\_\_\_\_ Policy Holder: \_\_\_\_\_

**\*\*\*Please complete this section and check for errors above.**

Sex: Male \_\_\_\_\_ Female \_\_\_\_\_ Occupation: \_\_\_\_\_

Business/Employer: \_\_\_\_\_ Alternate Contact Person: \_\_\_\_\_

Name of Family Doctor \_\_\_\_\_ Alternate Contacts Phone #: \_\_\_\_\_

Doctors Location \_\_\_\_\_ Referred By: \_\_\_\_\_

Doctors Phone : \_\_\_\_\_ Number of Children: \_\_\_\_\_

May we contact your doctor? \_\_\_\_\_ Marital Status: \_\_\_\_\_

**Email Address:** \_\_\_\_\_

**I authorize the release of any medical information necessary to process this claim. I have read the Privacy Notice of this Clinic. I also request payment of government benefits either to myself or to the party who accepts assignment below. I authorize payment of medical benefits to Allied Chiropractic, P.A.**

Signed: \_\_\_\_\_ Date: \_\_\_\_\_

### Consent For Treatment Of A Minor

I hereby authorize Allied Chiropractic, P. A. to evaluate and treat \_\_\_\_\_ This may include the use of X-ray.

Signed \_\_\_\_\_ Relationship to minor \_\_\_\_\_

Print Name \_\_\_\_\_ Date \_\_\_\_\_

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\*\*\*\*\***For Office Use Only**\*\*\*\*\*

- |  |  |
|--|--|
| <input type="checkbox"/> File                                | <input type="checkbox"/> Schedule of Care                |
| <input type="checkbox"/> Diagnosis / Disability              | <input type="checkbox"/> New Patient Phone Call          |
| <input type="checkbox"/> Financial Discussed                 | <input type="checkbox"/> Treatment Card Complete         |
| <input type="checkbox"/> Insurance Information Obtained      | <input type="checkbox"/> Exam Form Signed                |
| <input type="checkbox"/> Insurance Formed Signed             | <input type="checkbox"/> ROF reported                    |
| <input type="checkbox"/> Computer Entries                    | <input type="checkbox"/> Letter to Family Doctor         |
| <input type="checkbox"/> Consultation and Exam Transcription | <input type="checkbox"/> Advocate Follow-Up Call Ordered |
| <input type="checkbox"/> Treatment Card Completed            |  |
| <input type="checkbox"/> Add to Mailing List in Microsoft    |  |
| <input type="checkbox"/> Verify Insurance                    |  |
| <input type="checkbox"/> Referral checklist                  |  |
| <input type="checkbox"/> Feedback Letter                     |  |