

Sussex Chiropractic, Wellness & Massage, S.C.

Patient Case History

Confidential Patient Information:

Date: _____

Name: _____

Address/City/Zip: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

E-mail Address Home: _____ E-mail Address Work: _____

Social Security Number: _____

Your Age: _____ Birth date: _____ Marital Status: M S W D

Your Employer: _____ Occupation: _____

Name of Spouse: _____ Number of Children: _____

Health Insurance Carrier: _____

Insured's Name: _____ Insured's SS Number: _____

Insured's Date of Birth: _____ Insured's Employer: _____

Please check any and all insurance coverage that may be applicable in this case:

Major Medical ___ Worker's Comp ___ Medicaid ___ Medicare ___ Auto Accident ___ Other ___

Emergency Contact Name: _____ Phone: _____

PURPOSE OF THIS APPOINTMENT: _____

Have you seen other doctors for this condition: _____

Date of Last Physical Exam: _____

Have you had any operations: _____

If yes, what kind _____

Are you taking any prescriptions: Y N If yes, please name them: _____

Please tell us how you were referred to our office: _____

AUTHORIZATION AND RELEASE: I understand that if I am accepted as a patient of Dr. Loftus, I am authorizing them to proceed further with any treatment that may be necessary to improve my condition. I further understand that no cures are promised or implied. Any risks involving chiropractic treatment will be explained to me upon request. I understand that the amount paid for x-rays is for examination only and the x-ray negatives will remain the property of this office.

I authorize the doctor to release all information necessary to communicate with personal physicians and other healthcare providers and payors and to secure the payment of benefits. I understand and agree to allow this chiropractic office to use my Patient Health Information (PHI) for the purpose of treatment, payment, healthcare operations and coordination of care.

I understand that I am responsible for all costs of chiropractic care, regardless of insurance coverage. I also understand that if I suspend or terminate care as determined by my treating doctor, any fees for services will be immediately due and payable. I understand that interest is charged on overdue accounts at the annual rate of 18%.

PATIENT'S SIGNATURE: _____ Date _____

CONSENT TO TREAT MINOR UNDER 18 _____

GUARDIAN'S AUTHORIZED SIGNATURE _____