Patient Information:

Patient Name:_____ Date of Birth:_____
First MI Last

SSN: _____Age:_____ Gender: Male/Female Marital Status: M S D W #of Children____

Mailing Address:_____City:_____

State:_____ Zip:_____ Home Phone:_____ Cell Phone:_____

Work Phone: _____May we contact you at work number? Yes_____ No _____

Occupation:_____ Employer: _____

Name of Family Medical Doctor:_____

Spouse's Name:_____ Spouse's Date of Birth:_____

Spouse's Employer: _____ Spouse's Work Phone: _____

Minors: ***(age 17 & under)*** - Parent/Guardian Contact Information for Appointments, etc.

Name: _____ Relationship:_____

Best Contact Phone Number: _____

HIPPA: Please list anyone (spouse, parent, child, etc.) who has authorization to access the information listed.

Name: _____☐ Appointment☐ Insurance/Billing/Payment☐ Treatment

Name: _____☐ Appointment☐ Insurance/Billing/Payment☐ Treatment

---

How did you find out about this office? (Please choose **ONE** of the following and list name.)

☐ Relative: _____ ☐ Friend:_____

☐ Doctor: _____ ☐ Insurance Plan: _____

☐ Phone Book ☐ Dr. Flora's Website ☐ ART Website ☐ Office Location ☐ Other: _____

Chiropractic examination and therapeutic procedures (including spinal adjustment, ultrasound, electrotherapy, and manual muscle therapy) are considered safe and effective methods of care. Occasionally, however, complications may arise. Any procedure intended to help may have complications. While the chances of experiencing complications are small, it is the practice of this office to inform our patients about them. Side effects include, but are not limited to, soreness, inflammation, soft tissue injury, dizziness, and temporary worsening of symptoms. More serious complication are extremely rare and their association with spinal adjustments (manipulation) is debated. These complications include injury to the arteries in the neck which may be associated with stroke, and injuries to the spinal discs. Serious complications are estimated to be in the range of .5-2 incidents per million adjustments of the neck, and 1 per million for adjustments of the low back.

I have read and understand the above statements regarding treatment side-effects. I also understand that there is no guarantee or warranty for a specific cure or result.

Signature: _____ **Date:** _____
(Patient or Parent/legal guardian)

I authorize the release of any medical information necessary to process this claim and request payment of medical benefits to Flora Chiropractic & Sports Clinic. Verification of insurance benefits and/or a written referral by my primary physician is not a guarantee of payment by my insurance company. If payment is denied for any reason, I agree to be personally and fully responsible for any unpaid balances. **I understand that I am ultimately responsible for all charges incurred at this office.**

Signature: _____ **Date:** _____
(Patient or Parent/legal guardian)