SHOREWOOD FAMILY
CHIROPRACTIC

4433 N Oakland Ave
Shorewood, WI 53211

NEW PATIENT INFORMATION

Name _____ Date _____

Address _____ City _____ Zip _____

Phone _____ Age _____ D.O.B. _____ E-mail _____

Cell Phone _____ Cell Phone Carrier _____

Employer _____ Student: full ____ part _____

Occupation_____ Start Date_____

Work Phone _____ Single _____ Married _____

Relationship to Insured: self _____ spouse _____ child _____

Insd's Name _____ Date of Birth _____

Insd's Address _____ City _____ Zip _____

Insd's Phone _____ Insd's Employer _____

Insd's work phone _____

Medical Doctor _____ Clinic _____

In case of Emergency call _____ Phone _____

Referred By: ◯ Internet/Website ◯ Insurance ◯ Location ◯ Advertisement

◯ Patient _____ ◯ Medical Professional_____

I hereby give my permission to Shorewood Family Chiropractic to release any information requested by my insurance company acquired in the course of my examination and treatment. I hereby authorize and direct my insurance benefits to be paid directly to Shorewood Family Chiropractic. I take responsibility for verifying my insurance benefits, and I am aware that I am financially responsible for all services rendered to me. I understand and agree to allow this chiropractic office to use their Patient Health Information for the purpose of treatment, payment, healthcare operations, and coordination of care. We want you to know how your Patient Health Information is going to be used in this office and your rights concerning those records. If you would like to have a more detailed account of our policies concerning the privacy of your Patient Health Information, we encourage you to read the HIPPA NOTICE that is available to you at the front desk before signing this consent.
I have read and agree to the above statement.

Signature _____ Date _____