PATIENT INFORMATION

WELCOME! PLEASE PRINT

Full Name____ Prefer to be called: __________________
Address____ City__________________
State______ Zip___________
Home Phone # (______)_______--________ S/S#________-_____-________ Birth Date_____________
Cell # (______)________--_____________Work Phone # (______)________--____________Ext:______
Marital Status: **S M W D Sep** No. of Children_____ **Email**__________________________________
Employer ________________________________ Occupation_________________ Years on Job_____
Employer's Address______________________________________ City__________________
State______ Zip___________
Spouse/Parent/Guardian Name __________________________________ Spouse Birth Date_______
Spouse's Employer____________________________________ Occupation___________________
Employer's Address_____________________________________ City__________________
State_____ Zip________
Work Phone # (______)________--______________ Ext:________
Emergency Contact____________________________________ Relationship: _________________
Phone # (_______)______--__________
How were you referred to this office? ____
Name of Family Doctor: __________________________________ May we contact him/her? **Yes No**
Is your condition due to an accident or work injury? (circle one) No Yes, Date _____________

CHIROPRACTIC TREATMENT CONSENT

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures. I understand and am informed that, as in the practice of medicine, in the practice of chiropractic there are **some risks to treatment including, but not limited to, fractures, disk injuries, strokes, dislocations and sprains**. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely on the doctor to exercise judgment during the course of treatment concerning which treatment(s) are in my best interests, based upon the facts as they are then known.

X____ _______/_______/_______
Signature of Patient (Parent/Guardian if a Minor) Date

AUTHORIZATION/FINANCIAL RESPONSIBILITY

I authorize Gauthier Chiropractic, LLC to release any information concerning my diagnosis and medical records about any treatment or examination rendered to me or my child during the period of chiropractic care to third party payer and/or health practitioners. I authorize and request my insurance company to pay Gauthier Chiropractic, LLC directly for insurance benefits otherwise payable to me. I understand that my insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered to me or my dependents. **I understand that payment for services and/or the applicable co-payment is due at the time of service.**

X____ _______/_______/_______
Signature of Patient (Parent/Guardian if a Minor) Date Payment

Payment Options Available: ☐ **Cash** ☐ **Check** ☐ **Credit Card** ☐ **Discover** ☐ **Payment Plans (if needed)**