

Welcome to Hood Chiropractic

Please complete all sections and all questions. Thank You.

Today's Date _____

Patient _____

Address _____

Male Female Age _____ Birth date _____

Patient SS# _____

Single Married Widowed Divorced

Patient's Occupation _____

Patient's Employer _____

Employer's Address _____

Employer's Phone _____

Spouse's Name _____

Birth date _____ SS# _____

Occupation _____

Spouse's Employer _____

Home Phone: _____

Cell Phone: _____ Cell Carrier: _____

Work Phone: _____

Patient's Email: _____

(We will NOT sell your e-mail address to anyone!)

IN CASE OF EMERGENCY, WHO MAY WE CONTACT:

Name: _____

Home Phone: _____

Work Phone: _____

Cell Phone: _____

Whom May We Thank For Referring You? _____

Billboard Yellow Pages Newspaper Ad

Patient Family Member/ Friend Website

Radio Other _____

Who is responsible for this account? _____

Relationship to Patient _____

Insurance Company _____

Subscriber's Name _____

Birth date _____ SSN _____

ASSIGNMENT AND RELEASE

I, the undersigned certify that I (or my dependent) have insurance coverage with _____ and assign directly to Dr. Kelly Hood all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions. I also certify that I am not presently enrolled in a HMO.

Responsible Party

I do hereby acknowledge that the above information is true and correct to the best of my knowledge.

VERIFICATION OF NON-PREGNANCY (Female Patients Only): By my signature on this form I do hereby state to the best of my knowledge, I am NOT pregnant, nor is pregnancy suspected or confirmed at this particular time.

Date of last menstrual period: _____

CONSENT TO TREAT MINOR CHILD (if applicable): I hereby authorize the clinical and ancillary staff of Hood Chiropractic & Wellness Center, PA to administer treatment as they do deem necessary to my

(Son/Daughter)

(Name of Minor)

CONSENT FOR TREATMENT: I voluntarily consent to the rendering of care, including treatment and performance of diagnostic procedures. I understand that I am under the care and supervision of the attending doctor and it is the responsibility of the staff to carry out instructions of such doctor.

PATIENT/Legal Guardian's Signature: _____

Date: _____