PATIENT INFORMATION

Name: ____ Date of Birth: _________________ Male____ Female_____

Social Security #: ____________________________________ Marital Status: Single/ Mar/ Div/ Other

Address: ____ City: ____________________ State: ____ Zip: ____________

Home Phone: _____________________ Cell Phone: ____________________ Email:______________________________

Occupation: __________________________ Employer: ________________________ Work Phone: _________________

Are you a minor? Yes or No Emergency Contact Name:_______________________________________

Emergency Contact Phone #:_______________________ Relation:______________________________

APPOINTMENT REMINDERS

Would you like to receive our automated appointment reminders? Yes **or** No

If yes, please choose ONE option and fill out applicable section below: Text **or** Email

Cell Phone: ______________________________ Service Carrier (ex. AT&T/Verizon): ____________________________

Email Address: ____

How far in advance would you like your reminder? (circle one): 30min 1hr 2hr 4hr 1-day 2-days 1-week

INSURANCE INFORMATION

Primary Insurance: ____ Phone: _________________________________

Subscriber (if not yourself): ______________________________________ Date of Birth: __________________________

Subscriber Member ID: _________________________ Group #: ____________________ SSN: ____________________

Is there another health insurance? ____ Yes ____ No **If Yes, Please Complete the Following:**

Insurance Company: ____ Phone: _____________________________

Subscriber: ____ Subscriber Date of Birth: _______________________

Subscriber Member ID: _________________________ Group #:_____________________ SSN: ____________________

IS YOUR VISIT TODAY THE RESULT OF AN ACCIDENT? No___ Yes ___ **IF YES, WHAT KIND OF ACCIDENT?**

☐ Motor Vehicle: ☐ Worker's Comp: ☐ Other:

Claim Number: _______________________ Claim Adjuster: __________________________ Phone: ________________

Attorney Name & Company(if applicable): ____ Phone: _________________

Periodically, we may need to contact you to confirm appointments, discuss your care or your account.

May we have permission to leave a detailed message on your phone or email? No___ Yes___

Whom may we thank for referring you? ____

PLEASE TURN THE PAGE OVER TO CONTINUE.

PATIENT INFORMED CONSENT

I hereby request and consent to the performance of chiropractic adjustments, computerized range of motion, examination procedures, including diagnostic x-ray on me (or on the patient named below, for whom I am legally responsible) by any licensed chiropractor who treats me at Mukilteo Chiropractic Clinic. I am responsible for informing the doctor if I am pregnant or might be pregnant PRIOR to having x-rays.

I will have an opportunity to discuss with my doctor and/or other office personnel the nature and purpose of chiropractic adjustments and other procedures. I understand that patients experience an audible "pop" during a manual adjustment and this is a normal part of treatment. Our doctors perform full spine adjustments, which may include area other than my chief complaint, in an effort to correct the biomechanics of my spine as a whole.

I understand and am informed that, as in the practice of medicine, the practice of chiropractic has some risks to treatment, including, but not limited to fractures, disc injuries, strokes, dislocations and sprains. I do not expect the doctor to be able to anticipate and explain all risks and complications of the procedure which the doctor feels at the time, based upon the facts then known, is in my best interest. According to research the probability of serious injury is 1:1,000,000. I understand that 40% on non-symptomatic patients have disc herniations, which may exist in my spine and become symptomatic whether or not I receive treatment.

I have read, or have had read to me, the above consent and I understand. I will also have an opportunity to ask questions about its content, and by signing below I agree to the above named procedure. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) and for which I seek treatment.

HIPAA NOTICE/INSURANCE ASSIGNMENT/RELEASE & AGREEMENT

I have received and reviewed HIPAA related privacy information. I authorize my insurance benefits to be paid directly to Dr Kreutz and/or Mukilteo Chiropractic Clinic (MCC). I authorize MCC to release any information required to process my insurance claims. This authorization is in effect until my account is paid in full. I understand I am ultimately responsible for services rendered, regardless of my insurance benefits, which have been explained to me. In the event my treatment is the result of a motor vehicle accident or worker's compensation claim, MCC may discuss or release information to my attorney or claims manager or their representatives.

Patient Name: ____________________________ Signature: _____________________________ Date: ________

Name of Parent/Legal Representative (If applicable): ____
Parent/Representative Signature : __________________________________Date: _________________________

Ins verified? ___ PIP questionnaire completed? ___ Financial Consult? ____