DAVEN L. SPENCER, D.C.

Dedicated to Quality Chiropractic Care, NOT Quantity Care!

CONFIDENTIAL PATIENT INFORMATION

Name:_____ Date:_____

Address:_____
(City) (State) (Zip)

Home Phone:_____ Work or Mobile Phone:_____

Email address: _____

Sex: ___Male ___Female Birth date:_____ Age:_____

Social Sec. #:_____ Marital Status: ___Single ___Married ___Divorced

Occupation:_____ Employer:_____

Work Address:_____
(City) (State) (Zip)

Spouse's Name:_____ Employer:_____

How did you find us?: ___Referral ___Phone Book ___Newspaper ___Internet ___Drive by

Insurance Name:_____ Policy or Claim #:_____

Policyholder Name:_____ Policyholder Birth date:_____

Attorney Name (If applicable):_____ Phone:_____

When did Symptoms start?:_____

Is this visit related to an accident? ___Yes ___No If Yes, circle type: car, work, home, other _____

Are you now seeing or have you seen another Doctor for this condition? ___Yes ___No

RELEASE AUTHORIZATION

I hereby authorize Daven L. Spencer DC to release information regarding my medical condition and/or treatment history to my primary care physician, or for billing purposes, to my insurance company and/or attorney.

Signature:_____ Date:_____

FINANCIAL AGREEMENT/HIPPA COMPLIANCE

I understand that it is my responsibility to pay for Chiropractic services as they are rendered. If my insurance is to be billed, I authorize payments to be made directly to Daven L. Spencer DC. I will pay any portion of my bill not covered by insurance on the date of service. I also understand and have been informed that under the rules of HIPPA, there is a "Notice of Privacy Practices" policy that may be available to me at any time to read and review.

Signature:_____ Date:_____