



OptimalHealth

& Wellness Center, Ltd.

Patient Information

Welcome: Please complete this form, printing clearly and to the best of your knowledge.

Last Name _____ First Name _____ Middle Initial _____
 Email address _____ Gender M F Age _____ Birth Date ____/____/____
 Address _____ City _____ State _____ Zip _____
 (circle one) S M W D Sep Live-in Partner No. of Minor Children _____ Home Phone (____) _____
 SS# _____ Driver's License # _____ Cell Phone (____) _____
 Your Employer _____ Your Occupation _____ Work Phone (____) _____
 Employer Address _____ City _____ State _____ Zip _____
 Do you have health insurance where you work? Yes No Plan/Group # _____
 Insurance Company _____
 Name of Spouse, Parent or Guardian _____ Age _____ Birth Date _____ SS# _____
 Spouse's Employer _____ Spouse's Occupation _____ Work Phone (____) _____
 In case of Emergency Contact: _____ Relationship _____
 Home Phone (____) _____ Cell Phone (____) _____ Work Phone (____) _____
 Primary Care Physician _____ Telephone (____) _____
 May we contact your physician to provide health updates? Yes No

How did you find out about our office, or whom may we thank for referring you? _____

Disclosure of Information

All information provided to the Optimal Health & Wellness Center is strictly confidential except for the following circumstances:

- 1) Your insurance company requests information about you in order to verify eligibility/process a claim or certify care.
- 2) The patient authorizes the release of information by signing a release form naming the specific person to receive the information.
- 3) Certain circumstances where we are required by law to release patient information (e.g. court subpoena, suspected abuse, etc.)

If you would like to have a more detailed account of our policies and procedures concerning the privacy of your Patient Health Information, we encourage you to read the privacy notice that is available to you at the front desk before signing this consent.

Acknowledgement and Agreement

The undersigned acknowledges that he/she has registered chiropractic healthcare services from the Optimal Health & Wellness Center. If chiropractic is not the optimal solution, we will refer you to a professional better suited to provide the consul/care you need. Be assured that all consultations and procedures in our office are done with your full knowledge and consent.

- We invite you to discuss with us any questions regarding our services. The best services are based on friendly, mutual understanding between Doctor & patient.
- I authorize the staff to perform any necessary services needed during diagnosis and treatment. I also authorize the Doctor to release any information required to verify insurance coverage.
- I understand the doctor and any other practitioner/therapist operating within this office space are considered separate and distinct legal practices.
- I understand that I am financially responsible for any and all charges for services rendered.
- I understand the above information and consent to the chiropractic treatment to be received.

I hereby state that the above information is true and correct to the best of my knowledge:

Patient Signature _____ **Date** _____

Spouse's or Guardian's Signature _____ **Date** _____