HUDSON CHIROPRACTIC

Name _____ Age _____ DOB _____/_____/_____

Email _____ SS# _____-_____-_____

Address _____ City _____ State _____ Zip _____

Marital Status: S M D W # of Children _____

Home Phone _____ Cell Phone _____ Work Phone _____

Name of Spouse or Guardian _____ DOB _____/_____/_____

Spouse SS# _____-_____-_____ Spouse Employment _____

Where are you Employed? _____ Address _____

Occupation _____ How did you hear about us? _____

Have you had previous Chiropractic care? Yes / No If yes, how long ago? _____

List any surgeries (and dates) you have had _____

_____

Family History (Such as cancer, Diabetes, High Blood Pressure, etc.) _____

_____

List **ALL** medications and supplements you are currently taking _____

_____

TO THE PATIENT: Please list below your chief complaints in order of their importance.

1 _____ How long? _____

2 _____ How long? _____

3 _____ How long? _____

Is this condition related to an accident? Yes / No Date of Acciden _____

Is this condition related to Employment? Yes / No Auto Accident? Yes / No

Other, explain _____

Have you sought medical treatment for this/these problems? Yes / No

Name of Doctor seen _____ Primary Care Physician _____

Are you here for: Relief of symptoms? Yes / No Correction of Problem? Yes / No

Follow-up care after correction? Yes / No

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INSURANCE INFORMATION

Name of Insurance Company _____

Name of policy Holder _____ Relationship to Patient _____

ID # _____ Group # _____

AUTHORIZATION AND RELEASE

I hereby authorize release of information necessary to file claims with my insurance company and assign payments of the benefits I am entitled under the provisions of my policy to **Seth M. Hudson, D.C.** of Hudson Chiropractic at the Pillar Chiropractic Physicians Centre. In addition to the foregoing, I hereby authorize the release of my medical information by or between any of my treating physicians and my insurer, HMO, health benefits payor of any other entity (including but not limited to third party administrators, management companies and provider networks) involved in administration of my health benefits.

I understand I am financially responsible for payment of this account regardless of insurance or other third party involvement. If the account is sent to an attorney or collection agency, I will be responsible for any collection fee and/or court costs.

Signature_____ Date _____/_____/_____

MEDICARE AUTHORIZTION AND RELEASE: Medicare patients ONLY

I request payment of authorized Medicare, Medigap, and/or any other insurance benefits be made to **Seth M. Hudson, D.C.** of Hudson Chiropractic at the Pillar Chiropractic Physicians Centre for any services furnished to me by the provider.

I understand my signature requests that payment be made and authorizes release of medical information necessary to determine benefits payable for services from this provider.

In Medicare assigned cases, the provider agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, co-insurance, non-covered services as ultrasound, electric muscle stimulation, traction, etc. Co-insurance and the deductible are based upon the charge determination of the Medicare carrier.

I understand that I am finally responsible for all charges whether or not paid by said insurance. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid and original.

Signature _____ Date _____/_____/_____