

Niequist Chiropractic Clinic, LTD.

"Empowering People To Live Healthy Lives"

Welcome to the Niequist Chiropractic Clinic

CONFIDENTIAL PERSONAL HISTORY

Date: ____/____/____

Name: _____
First MI. Last

Home Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____

E-Mail: _____ Cell Phone #: _____

Social Security # ____ - ____ - ____ Birth Date: ____/____/____ Sex: M F

Please check one: Married ____, Single ____, Widow ____, Divorced ____.

Name of spouse _____ No. of children _____

Referred by _____

HEALTH INSURANCE INFORMATION

Do you have insurance that may cover all or some of your chiropractic care?

Please check one: Yes ____ No ____

When did this condition begin? ____/____/____.

Is this condition the result of a **car accident**, **personal injury**, or **work related injury**?

Please **circle** which if any of the above apply.

Who is responsible for this account? _____

Relationship to patient _____

Insurance Company _____

Group # _____

Are you covered by additional insurance? _____

Insurance Company _____

Group # _____

CONSENT FOR RELEASE OF INFORMATION

I consent to the use or disclosure of my protected health information by Niequist Chiropractic Clinic for the purpose of analysis and providing chiropractic care and obtaining Pay for my healthcare bill, or to conduct healthcare operations.

My signature on this document is evidence of the consent.

I understand that I have the right to at any time to read the Niequist Clinic "Notice of Privacy Plan" as it relates to the handling of my protected health information.

Signature: _____ Date: _____

Witness: _____

For office use only: Patient # ____ New Patient ____ Update Patient ____