

Patient Information

Patient Name _____ Date _____

Address _____

City/State _____ Zip _____

Home Phone (____) _____ Date of Birth _____

Male ___ Female ___ S.S. Number _____ Marital Status M / S/ D/ W/ SEP

Employer _____ Employer's Phone Number _____

Employer's Address _____ City/State _____

Type of Insurance: Cash ___ Group ___ Work/Comp ___ Auto Accident ___ Medicare ___ Medicaid ___

Primary Insurance Name & Address _____

Insured's Name _____ Insured's D.O.B. _____

Policy Number _____ Relationship to Insured _____

In Case of Emergency Notify _____ Phone Number _____

FOR WORKER'S COMPENSATION AND PERSONAL INJURY ONLY:

Date of Accident _____ Time _____ a.m./p.m.

Supervisor's Name _____ Accident Report Completed? Yes ___ No ___

Describe In Detail Nature of Injury _____

RELEASE OF RECORDS: I hereby authorize the release of my records or copies of such to be sent to Dr. Dwain P. Porter, D.C. A photocopy of this authorization shall be considered as effective and valid as the original.

CONSENT TO TREAT A MINOR: I hereby authorize and request Dr. Dwain P. Porter, D.C. and his staff to administer such treatment deemed advisable, necessary or requested on the above minor. I agree to hold him free and harmless from any claims, suits for damages or complications, which may result from such treatment.

TO ALL FEMALES FOR X-RAY PURPOSE: I AM NOT PREGNANT AND HAVE NO REASON TO BELIEVE I AM PREGNANT. Sign _____

Patient Signature

Date

Parent or Guardian's Signature

Date