PATIENT INFORMATION

Personal Information

Name______________________________Date of Birth__________Age______
Mr, Ms, Dr. First Middle Last ❒ Minor
Address______________________________City__________State________Zip________
Home Phone______________Cell Phone______________Work Phone______________
E-Mail ______________________SS#______________ ❒Male ❒Female
Employer______________________Occupation______________________
Employer's Address______________________________
Spouse's Name______________________Employer______________________
Primary Care Physician ______________________Phone______________
Address______________________________
Preferred method of contact ❒ Home Phone ❒ Office Phone ❒ Cell Phone ❒ E-mail ❒ __________
Who may we thank for your Referral______________________________

Payment Information

How will you pay for your services?

❒Personal	Charged at full rates
❒ChiroUSA	Membership discount program (ask about details)
❒Health Insurance	Present card to the receptionist
❒Auto Insurance	Complete "Auto Accident" Form

Emergency Contact

Name ______________________Phone______________Relation__________
Name ______________________Phone______________Relation__________
Name ______________________Phone______________Relation__________

I am interested in learning more about other services offered at LifeSource Health Partners
❒Chiropractic ❒Massage ❒Acupuncture ❒Orthotics ❒Nutrition ❒Weight Loss/Gain

PLEASE PRESENT YOUR INSURANCE CARD TO THE RECEPTIONIST

I understand and agree that payment is due at time of service. I also agree that massage appointments must be canceled 24 hours in advance. If cancellation is not made within the 24 hour period, I am responsible to pay for the missed appointment.

If insurance is used, the insurance policies are an arrangement between me and the insurance company, and that LifeSource Health Partners will prepare necessary reports and forms to assist me in collecting from the insurance company. I agree that payments be made directly to LifeSource Health Partners and that the payments will be immediately credited to my account. However, I understand and agree that all treatments and services rendered to me are my responsibility.

Signature______________________________Date______________

Revised 9/13/2011