

WENGER CHIROPRACTIC GROUP

Computer # _____

Case # _____

PATIENT INFORMATION

Today's Date _____

Name: _____
(Last) (First) (MI)

Address: _____

City: _____ State: _____ Zip: _____

Telephone: Home # _____ Cell # _____ Work# _____

Social Security # _____ Date of Birth: _____

Policy Holder Employer: _____

Employer Address: _____ City: _____ State: _____ Zip: _____

Sex: M F Marital Status: Single Married Widowed Divorced

Spouse Name: _____ Parent/Guardian (if patient is under 18): _____

Who may we thank for referring you? _____

How did you learn about our office: Another Patient Yellow Pages Radio Medical Provider
 Insurance Directory Worker's Comp Panel Staff
 Health Fairs Other _____

Release of Information/Insurance Payment Authorization/Medical Records Release

This authorization, or photocopy hereof, will authorize the Wenger Chiropractic Group to furnish all information they may have regarding my condition while under care, including the history obtained, x-ray and physical findings, diagnosis and prognosis, to the responsible insurance carrier or other health care provider. Necessary information may be given to my employer concerning my condition. I also assign insurance benefits to the Wenger Chiropractic Group. I permit this office to endorse remittance for the conveyance of credit to my account. **HOWEVER, I CLEARLY UNDERSTAND AND AGREE THAT ALL SERVICES RENDERED TO ME ARE CHARGED DIRECTLY TO ME AND THAT I AM PERSONALLY RESPONSIBLE FOR PAYMENT.**

Signature _____ Date _____ Witness _____

Consent for Treatment

I authorize the doctors of the Wenger Chiropractic Group (WCG) and whoever he/she may designate as his/her assistant(s) to examine, perform diagnostic tests, including but not limited to radiographs, and to administer treatment as necessary. I understand that the doctors of the Wenger Chiropractic Group will do their best to obtain a positive result for my condition, however I certify that no guarantee is implied or made as to the results that may be obtained from treatment. If the patient is a minor, as parent/guardian, I give consent for treatment to be administered.

Signature _____ Date _____ Witness _____