Rum River CHIROPRACTIC

Personal Information:

Patient Name: _____ Date: _____

Date of Birth: _____ Age: _____ Sex: M or F Occupation: _____

Address: _____
Street City State Zip

Phone #: H: _____ C: _____ W: _____

For reminder calls, circle: **Home / Cell / Work**.

I would like a monthly health **e-newsletter**? **Y / N** Email: _____

Emergency Contact: _____ H: _____ C: _____

Assignment of Benefits and Records Release:

I authorize that my insurance benefits be paid directly to Rum River Chiropractic. I understand that I am financially responsible for any balance. I understand that accounts past due 30 days with no attempt at payment will be subject to an 18% annual finance charge, which will be added monthly (1.5%) to my account. I also authorize Rum River Chiropractic to release any information required to process my claims or release records to referral clinics.
_____ Yes _____ No

I authorize Rum River Chiropractic to leave a message on my answering machine, voicemail, or with the person who answers the phone at any of my contact numbers.
_____ Yes _____ No

I authorize Rum River Chiropractic to send my primary care physician a letter updating them on my condition.
_____ Yes _____ No Clinic and Dr. _____

Sign: _____ Date: _____

Who may we thank for your referral?

___ Internet ___ Phonebook ___ Insurance Directory ___ Driving By

___Referral (Name): _____ Other: _____