

APPLICATION FOR TREATMENT

Acct. #: _____

FC: _____

First Name: _____ MI: _____ Last Name: _____

Mailing Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: (____) _____ Work Phone: (____) _____ Cell Phone: (____) _____

Date of Birth: ____/____/____ Age: ____ Sex (Please Circle): Male Female

E-mail: _____ Social Security Number: ____ - ____ - ____

Marital Status (Please Circle): Married Single Widowed Divorced

How were you referred to our office: _____

Your Employer: _____ Occupation: _____

Spouse Name: _____ Spouse Phone: (____) _____

REQUIRED IF FILING HEALTH INSURANCE

Patient's Relationship to Primary Insured (please circle): Self Spouse Child Other Employee

Primary Insured's Name: _____

Primary Insured's Address: _____

Primary Insured's Date Of Birth: ____/____/____

Primary Insured's Employer Name: _____

METHOD OF PAYMENT

Please check and sign the method you prefer to use to pay for services rendered to you:

- _____ I have no applicable health insurance and will pay for my services with cash, check, or credit card.
- _____ I have health insurance (Please give appropriate cards to our staff so we can verify your coverage specifics)
- _____ I have been injured on the job and will be filing Worker's Compensation
- _____ I have been injured in an auto accident

Name of person responsible for account (if different from applicant): _____

I hereby authorize **McLaughlin Chiropractic Center** to examine me, including x-rays if indicated by the exam and to release my records to anyone I designate. I further authorize treatments deemed necessary by the findings and I wish that all my chiropractic records be held in strict confidence and not to be given to anyone without my written consent. I authorize payment directly to the doctor from my insurance company and I clearly understand that I am totally responsible for payment should my insurance company deny payment or make payment to me.

BY SIGNING YOUR NAME BELOW YOU CERTIFY THE ACCURACY OF YOUR MEDICAL AND/OR ACCIDENT HISTORY AND FURTHER CERTIFY THAT YOU PRESENT TO DR. McLAUGHLIN and whom he designates his Associates FOR EVALUATION AND/OR TREATMENT OF A HEALTH RELATED CONDITION AND FOR NO OTHER PURPOSE.

FIRST VISIT FEES ARE DUE AND PAYABLE AT THE TIME OF SERVICE.

Signature _____

Date ____/____/____