

PATIENT INFORMATION

Name: _____ Date: _____
Last First Middle

Address: _____
City State Zip Code

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Employer: _____ Referred By: _____

Social Security No.: _____ Birthdate: _____ Age: _____ Sex: Male Female

Primary Care Physician: _____ Spouse Name: _____

Emergency Contact Name and Phone No.:

INSURANCE INFORMATION

All services are considered cash unless full insurance information is provided.

Auto Accident : Yes No If Yes, Claim No.: _____ Date of Injury: _____

Work Related : Yes No If Yes, Claim No.: _____ Date of Injury: _____

Insured Name : _____ Relationship to Above: _____ Insured Birthdate: _____
(If other than self) (If other than self)

Primary Insurance: _____ ID No.: _____ Group ID No.: _____

Secondary Insurance: _____ ID No.: _____ Group ID No.: _____

Referral Needed? Yes No

RECORDS AUTHORIZATION

Yes No I authorize phone messages may be left on my answering machine.

I authorize my condition may be discussed with _____
(Spouse/family member, etc...)

CONSENT FOR PAYMENT AND TREATMENT

I authorize my insurance company to make payment directly to Oberg/Larsen Chiropractic in an amount equal to their contracted fee for treatment. I authorize Oberg/Larsen Chiropractic to release any information pertinent to any insurance company, adjuster attorney to facilitate collection by signing this agreement. I authorize Oberg/Larsen Chiropractic to examine any and all healthcare records pertaining to any injury or condition I am seen for. In the case of an auto accident or third party accident, I assign Oberg/Larsen Chiropractic any and all insurance benefits, settlement or judgement proceeds due to them, which are or shall become payable to me as a result of my injuries. I agree to see that all charges incurred with Oberg/Larsen Chiropractic are fully paid in the amount equal to their fee for treatment. I grant them an irrevocable lien on those benefits or proceeds for their fees. I am aware that I am solely responsible for paying Oberg/Larsen Chiropractic for all treatment and services rendered at their office. I understand that at any time they may demand full or partial payment of those services. I hereby consent to the performance of chiropractic treatment including but not limited to chiropractic adjustment, and diagnostic X-ray by Drs. Oberg and Larsen. I understand that no guarantee or assurance has been given about this treatment.

Patient's signature: _____ Date: _____

If minor, parent's signature: _____ Date: _____

MEDICARE DISCLAIMER

To our Medicare patients; We accept assignment on all Medicare patients and chiropractic treatment is a covered service. Exams for chiropractic treatment are a non-covered service with Medicare. Routine maintenance visits are a non-covered service with Medicare. Medicare will not pay for products sold by a Chiropractor (i.e. pillows, braces etc...) Charges not covered by Medicare or your supplemental insurance may become your responsibility. I have read and understand the above.

Patient's signature: _____ Date: _____