

**PATIENT INFORMATION**

Name \_\_\_\_\_ Date \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Phone: Home (\_\_\_\_) \_\_\_\_\_ Work (\_\_\_\_) \_\_\_\_\_ Cell (\_\_\_\_) \_\_\_\_\_

Birth date \_\_\_\_\_ SS# \_\_\_\_\_ Sex \_\_\_\_\_ Marital status \_\_\_\_\_

How did you find out about us? \_\_\_\_\_ Referred by \_\_\_\_\_

Place of employment \_\_\_\_\_

Are you employed full or part time? \_\_\_\_\_ Are you a student full or part time? \_\_\_\_\_

E-mail address (optional) \_\_\_\_\_

**FINANCIALLY RESPONSIBLE PERSON (if other than above)**

Name of responsible person \_\_\_\_\_ relationship \_\_\_\_\_

Full Address \_\_\_\_\_

Phone: Home \_\_\_\_\_ Work \_\_\_\_\_

SS# \_\_\_\_\_ Date Of Birth \_\_\_\_\_

**PLEASE INDICATE TYPE OF PAYMENT**

Self Pay \_\_\_\_\_ Medicare \_\_\_\_\_ Worker's Comp \_\_\_\_\_

**ACKNOWLEDGMENT OF PRIVACY NOTICE AND HIPAA CONSENT**

I acknowledge that I have been given the opportunity to review Keller Chiropractic's Notice of Privacy Practices and I consent to the use or disclosure of my protected health information by Keller Chiropractic for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills (if I am covered by Medicare or OBWC), or to conduct health care operations.

Signature \_\_\_\_\_ Date \_\_\_\_\_