CONFIDENTIAL PATIENT INFORMATION

Name _____ Date of birth _____

Address _____ SSN _____

City _____State _____ Zip code _____

Home Phone_____ Cell_____ Work_____

Married ____ Single ____ Widowed ____ Divorced ____

# of children _____ Ages _____

EMAIL address _____

Employer _____ Occupation _____

City _____ State _____ Zip code _____

Referred to our office by _____

Person to notify in case of emergency _____

Phone # _____

REASON FOR YOUR VISIT:

PRIMARY reason for your visit today? _____

SECONDARY reason for your visit today? _____

How long has it been since you felt good? _____

PAYMENT IS EXPECTED AT THE TIME OF VISIT:

I understand and agree that health and accident insurance policies are an arrangement between myself and my insurance carrier and that **Cornerstone Chiropractic Wellness, LLC does not** participate In-Network with any Insurance company, therefore I am responsible for payment in full at the time of my visit. I also authorize Dr. Shan Twit to release any of my health information to an attorney and/or insurance company, if required, in order to help process a claim or my case.

Patient's Signature _____Today's date _____

Guardian or Spouse's Signature _____

Person responsible for payment _____