

CONFIDENTIAL PATIENT INFORMATION

Name _____ Date of Birth _____ Current Age _____
Social Security No. _____ Driver's License No. _____ Marital Status M S W D
Address _____ City/State/Zip _____
Home Phone _____ Business Phone _____
Employer _____ Occupation _____
Employer Address _____ City/State/Zip _____
E-mail Address _____

Name of Spouse _____ Date of Birth _____ Current Age _____
Employer _____ Occupation _____

Nearest relative not living with you _____ Home Phone _____
Who should we contact in case of emergency? _____ Home Phone _____
Who can we thank for referring you to our office? _____

PURPOSE OF YOUR VISIT TODAY

List in order of importance - your current symptoms or current activity restrictions

1. _____ Painful Can not perform
2. _____ Painful Can not perform
3. _____ Painful Can not perform
4. _____ Painful Can not perform
Date of illness or onset _____ Time/Location _____
Related to accident? Auto On the job Other
List any other Doctors you have seen for this condition _____
Date of last physical exam _____ Results of exam/treatment rendered _____
Have you been treated by a Doctor for any health condition in the last year? (Who/when) _____
If yes, please explain _____

INSURANCE INFORMATION

Name of Primary Company Copy on file _____ Name of Secondary Company Copy on file _____
Address _____ Address _____
ID & Group No. _____ ID & Group No. _____
Phone No. _____ Phone No. _____

PAYMENT IS EXPECTED AT TIME OF VISIT

You will be paying today by: Cash Check Credit Card
Name of person responsible for payment _____

PATIENT RESPONSIBILITIES

I understand I am financially responsible WHETHER OR NOT MY INSURANCE COMPANY PAYS, for all charges incurred by me. I hereby assign my major medical insurance benefits, private insurance and other health plans (excluding Medicare) to Robert Scott, D.C. Any overpayment will be promptly refunded. I also authorize Robert Scott, D.C. to release any information needed to secure payment. If my balance becomes delinquent and suit is filed, I agree to pay all collection costs including attorney fees and court costs in addition to the above fee. Accounts over 60 days delinquent will be subjected to a monthly finance charge of the greater; 1.5%(18% annually) or \$10.00 re-billing fee monthly.

I understand that if I do not notify your office in advance, I will be charged a missed appointment fee equivalent to one office visit and if I miss three scheduled appointments I will be dismissed from care. This fee will not be billed to my insurance, worker's comp or attorney, but is due and payable by me directly before any further services are rendered. I have read, understand, and agree to comply with the above.

Patient's Signature _____ Date _____
Parent's or Guardian's Signature _____ Date _____

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