ESHBAUGH CHIROPRACTIC
PATIENT INFORMATION FORM

Patient's Name_____ Age_____Date of Birth_____
(First) (Middle Initial) (Last)

P.O Box:_____ **Marital Status (Circle One):** Single Married Divorced Widowed

Physical Address_____

City: _____ State: _____ Zip Code: _____

Social Security #___-_____-_____ Gender: _____ **Height:** _____ **Weight:** _____

Cell Phone: ( ) _____ Home Phone: _____

Race (Please Circle Only One): American Indian or Alaska Native African American/ Black Asian
Hispanic or Latino Native Hawaiian or Other Pacific Islander White

Ethnicity (Circle One Only): Hispanic or Latino Not Hispanic or Latino

Preferred Language: _____

Who may we thank for referring you to our office? _____

MEDICAL INSURANCE INFORMATION

(WE WILL NEED A COPY OF YOUR INSURANCE CARDS)

	Insurance Company	Policy #	Group #	Policy Holder	Policy holders DOB
1.					
2.					

IF PATIENT IS A CHILD OR A MINOR (if not skip to Authorization)

Child's Mother:_____Date of Birth: _____

Address_____City_____State_____Zip Code_____

Home Phone (_____)_____Cell# (_____)_____Work (_____)_____

Childs Father:_____Date of Birth_____

Address:_____City_____State_____Zip Code_____

Who is financially responsible for this child? _____

Relationship:_____Address (if different from parents)_____

City:_____State_____Zip Code:_____

INSURANCE INFORMATION: (if different from above) Whom is insurance coverage through?_____

Policy Holder:_____ ID#_____

Patient Name: _____

CONSENT TO TREAT A MINOR

I hereby authorize Dr. Daren Eshbaugh, D.C. and whomever he may designate as an assistant, to administer care as deemed necessary to treat my child_____.

Minor's Name (printed):_____

Parent/ Guardian Signature: _____

Parent/ Guardian Printed Name: _____

Authorization—PLEASE READ BEFORE SIGNING

To process my medical claims for payment, I_____, hereby authorize Eshbaugh Chiropractic or their authorized agents, to release copies of my medical records and/or provide information regarding my physical or mental condition and treatment rendered to my insurance carrier and/or any agent acting on the insurance carrier's behalf.

I also authorize Eshbaugh Chiropractic to release copies of my medical records to my primary care, family or other treating physicians.

I understand that if this is a workers' compensation claim the carrier may employ a rehabilitation or consulting firm to handle my case. I authorize the release of my medical records to the workers' compensation carrier and/ or rehabilitation or consulting firm.

I hereby assign to Eshbaugh Chiropractic all payments for medical services rendered to me and/or my dependents, and I understand and agree that any services not covered by my insurance carrier are my financial responsibility.

Signature of patient/parent/ legal guardian: _____

Printed Name:_____Date: _____

RECEIPT OF NOTICE OF PRIVACY PRACTICE

(HIPPA)

WRITTEN ACKNOWLEDGEMENT

I,_____, have been made aware of HIPPA, understand, and am in agreement to Eshbaugh Chiropractic's Notice of Privacy Practices regarding HIPPA.

_____

Signature of Patient/ Legal Guardian Date