

WELCOME

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PATIENT # _____

◆ PATIENT INFORMATION ◆

Date _____

Patient Name: _____ MID INT. _____

Address _____

City _____ State _____ Zip _____

Phone # _____

Cell Phone # _____

Sex: M F Age _____ Birthdate _____

Single Married Divorced Widowed

Patient Social Security # _____

Occupation _____

Employer/Phone # _____

◆ REFERRAL INFORMATION ◆

Who referred you? _____

Family Friend Advertising (where) _____

◆ ACCIDENT INFORMATION ◆

Is condition due to an accident? NO YES Date _____

Type of accident: Auto Work Home Other

To whom have you made a report of your accident?

Auto Insurance Employer Worker's Comp Other

◆ PATIENT CONDITION ◆

Describe your complaint (symptoms) in detail

◆ INSURANCE ◆

Name of Insurance 1) _____

2) _____

SUBSCRIBER'S BIRTHDATE: _____

Insured's Name: _____

Insured's Address _____

City _____ State _____ Zip _____

Insured's Social Security # _____

Insured's Employer _____

Is He/She Hourly Salary Employee?

◆ ASSIGNMENT AND RELEASE ◆

I, the undersigned certify that I (or my dependent) have insurance coverage with above named insurance company and assign directly to: Dr. Hubert W. Russell, Jr. of Russell Chiropractic Health Center, P.C. all insurance benefits, if any, otherwise payable to/by me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions. I agree to be financially responsible for all charges incurred at this clinic including my insurance deductible, co-payment, and any services rejected by my insurance company.

Patient Signature

Relationship

◆ CIRCLE YOUR CURRENT PAIN LEVEL ◆

<u>NECK</u>	low pain	moderate pain	intense pain
<u>MID BACK</u>	low pain	moderate pain	intense pain
<u>LOW BACK</u>	low pain	moderate pain	intense pain