

# Buettenback Chiropractic

*Take Charge of Your Health*  
(Please Print)

Today's Date \_\_\_\_/\_\_\_\_/\_\_\_\_

Patient Number: \_\_\_\_\_ (office use only)

## PATIENT INFORMATION

Patient's Last Name		First	Middle Initial	Marital Status (Circle One)		
				Single / Mar / Div / Sep / Wid		
Street Address		City	State	ZIP Code	Birth Date	Age
					/ /	
Social Security		Home Phone No.	Cell Phone	Email: Include your email to be notified of appts. and/or to receive our newsletter		
		( )	( )			
Occupation			Employer	Employer Phone No.		
				( )		
Spouse Name		Occupation		Employer		
How did you hear about us? <input type="checkbox"/> Referred by Dr. _____ <input type="checkbox"/> Referred by _____						
<input type="checkbox"/> TV Commercial <input type="checkbox"/> Outdoor Sign <input type="checkbox"/> Yellow Pages <input type="checkbox"/> Radio <input type="checkbox"/> Insurance Plan <input type="checkbox"/> Other _____						
*We like to thank those that refer to our office. Please let us know if someone referred you. Thanks!						
Other Family Members Seen Here _____						

## INSURANCE INFORMATION (PLEASE GIVE YOUR INSURANCE CARD TO THE RECEPTIONIST)

Person Responsible for Bill		Birth Date	Address (if different)		Home Phone No.
		/ /			
Is this person a patient here?		<input type="checkbox"/> Yes <input type="checkbox"/> No		( )	
Occupation		Employer	Employer Address		Employer Phone No.
					( )
Please check any and all insurance coverage that may be applied in this case:					
<input type="checkbox"/> Major Medical <input type="checkbox"/> Medicaid <input type="checkbox"/> Medicare <input type="checkbox"/> Auto Accident <input type="checkbox"/> Worker's Compensation					
<input type="checkbox"/> Other _____					
Name of Primary Insurance Company _____					

Subscriber's Name		Subscriber's S.S. #	Birth Date	Group #	Policy #	Co-Payment
			/ /			\$
Patient's Relationship to Subscriber <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other _____						
Name of Secondary Insurance (if applicable)			Subscriber's Name		Group #	Policy #
Patient's Relationship to Subscriber <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other _____						

## IN CASE OF EMERGENCY

Name of Local Friend or Relative (not living at same address)		Relationship to Patient	Home Phone No.	Work Phone No.
			( )	( )

## PATIENT HEALTH HISTORY

Family Medical Doctor

Purpose of this appointment

Date Symptoms first appeared

/ /

Have you ever had the same or similar condition?

Yes  No

If yes, please explain

## PATIENT HEALTH HISTORY (CONTINUED)

Days lost from work

What surgeries have you had ( include dates)

Date of last Physical Exam

Serious Illnesses ( include dates)

/ /

Have you been treated for any health condition by a physician in the last year

Yes  No

If yes, please explain

What medications or drugs are you currently taking?

**AUTHORIZATION AND RELEASE:** I authorize payment of insurance benefits directly to Dr. Ben Buettenback or Buettenback Chiropractic. I authorize the doctor to release all information necessary to communicate with personal physicians and other healthcare providers and payors and to secure the payment of benefits. I understand that I am responsible for all costs of chiropractic care, regardless of insurance coverage. I also understand that if I suspend or terminate my schedule of care as determined by my treating doctor, any fees for professional services will be immediately due and payable.

The patient understands and agrees to allow Buettenback Chiropractic to use their Patient Health Information for the purpose of treatment, payment, healthcare operations, and coordination of care. We want you to know how your Patient Health Information is going to be used in this office and your rights concerning those records. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your Patient Health Information we encourage you to read the HIPAA NOTICE that is available to you at the front desk before signing this consent. If there is anyone you do not want to receive your medical records, please inform our office.

X

\_\_\_\_\_  
PATIENT/GUARDIAN SIGNATURE

\_\_\_\_\_  
DATE