SEAMAN CHIROPRACTIC CONFIDENTIAL PATIENT RECORD

Occupation ________________________________ E-Mail Address ______________________________________

Cell Phone Number______________________________ Pager Number ________________________________

Employer____ Work Phone______________________ext._____

Address____

Check if you are: ___Married ___Single ___Widowed ___Divorced ___Separated

Spouse's Name____

Spouse's Employer____________________________Address____

Whom to Contact in Case of an Emergency: (different from above)

Name____ Relation_________________________

Home Phone______________________________________ Work Phone__________________________________

Family Doctor____ Cross Streets__________________________

Person Responsible for Payment: ___Self ___Spouse ___Employer ___Insurance ___Other__________

Address____City/State_________________________________Zip_____

Home Phone____ Work Phone_____________________ext.___

Owner of Policy_________________ Policy#_________________________ Group#________________________

Name of Insurance____ Deductible_____________

ASSIGNMENT OF BENEFITS

In consideration of your undertaking to treat me, I hereby agree to the following:

1. You are authorized to release any information you deem appropriate concerning my physical condition to my insurance company, attorney or adjuster in order to process any claim for reimbursement of charges incurred for services rendered to me by you or any member of your staff acting on your behalf.

2. I authorize the direct payment to you of any sum I now or hereafter owe you by any insurance company obligated to reimburse me for the charges for your services or otherwise obligated to make payment to me or you based in whole or in part upon the charges made for your services. I also authorize the direct payment to you by my attorney out of the proceeds of any settlement of any claim based in whole or in part upon the charges made for your services.

3. In the event any insurance company obligated by contractual agreement to make payment to me or to you for the charges made for your services refuses to make such payment upon demand by you, it is my understanding that I am responsible for your charges in full, and payment for services rendered will be made on a current basis and my account paid in full immediately.

4. I hereby state and agree that a photocopy of this document will be deemed as valid and binding on all parties involved as the original copy.

____ ____________________________

Patient's Signature (or Parent/Guardian, if a minor) Date