



# PATIENT INFORMATION

## Personal Information

Name _____			Date of Birth _____	Age _____
Mr, Ms, Dr.	First	Middle	Last	<input type="checkbox"/> Minor
Address _____			City _____	State _____ Zip _____
Home Phone _____		Cell Phone _____	Work Phone _____	
E-Mail _____		SS# _____	<input type="checkbox"/> Male <input type="checkbox"/> Female	
Employer _____		Occupation _____		
Employer's Address _____				
Spouse's Name _____		Employer _____		
Primary Care Physician _____			Phone _____	
Address _____				
Preferred method of contact <input type="checkbox"/> Home Phone <input type="checkbox"/> Office Phone <input type="checkbox"/> Cell Phone <input type="checkbox"/> E-mail <input type="checkbox"/> _____				
Who may we thank for your Referral _____				

## Payment Information

How will you pay for your services?	
<input type="checkbox"/> Personal	Charged at full rates
<input type="checkbox"/> ChiroUSA	Membership discount program (ask about details)
<input type="checkbox"/> Health Insurance	Present card to the receptionist
<input type="checkbox"/> Auto Insurance	Complete "Auto Accident" Form

## Emergency Contact

Name _____	Phone _____	Relation _____
Name _____	Phone _____	Relation _____
Name _____	Phone _____	Relation _____

I am interested in learning more about other services offered at LifeSource Health Partners  
 Chiropractic  Massage  Acupuncture  Orthotics  Nutrition  Weight Loss/Gain

### PLEASE PRESENT YOUR INSURANCE CARD TO THE RECEPTIONIST

I understand and agree that payment is due at time of service. I also agree that massage appointments must be canceled 24 hours in advance. If cancellation is not made within the 24 hour period, I am responsible to pay for the missed appointment.	
If insurance is used, the insurance policies are an arrangement between me and the insurance company, and that LifeSource Health Partners will prepare necessary reports and forms to assist me in collecting from the insurance company. I agree that payments be made directly to LifeSource Health Partners and that the payments will be immediately credited to my account. However, I understand and agree that all treatments and services rendered to me are my responsibility.	
Signature _____	Date _____