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# Welcome! Please provide the following information for your confidential file.

## Personal

**Name** First ______________________

Middle ______________________

Last ______________________

**Sex** □ Male □ Female

**Date of Birth** _______/_______/______________ (mm/dd/yyyy)

**Address** Street ______________________

City ______________________

State ______________________

Zip ______________________

**Phone** Home (________) - _______ - _____________

Business (________) - _______ - _____________

Cell (________) - _______ - _____________

**E-Mail Address** ______________________

## Insurance

□ **Self-Pay / No Coverage. (If not using insurance, please check box and proceed to next section.)**

**Insured's Name** ______________________

**Relationship to patient** ______________________

**Insured's Employer** ______________________

**Insurance Co.** Name ______________________

**Insurance Co. Billing** PO Box/St. ______________________

City ______________________

State ______________________

Zip Code ______________________

Phone (________) - _______ - _____________

Group # ______________________

ID # ______________________

Electronic ID# ______________________

## Personal Information - Part 2

**Employment Status** ◻ Employed ◻ Retired ◻ Other ____________________

**Employer** ____________________

**Occupation** ____________________

**Describe what you do at work** ____________________

____________________

____________________

**Retirement Date** _______/_______/_______________ (mm/dd/yyyy)

**Sports, Hobbies, Other Interests** ____________________

____________________

____________________

## Additional Health Professionals with whom you consult ( MD, DO, DPM, PT, etc.) *

**Name** ____________________ **Phone** (________) - _______ - _____________

**Name** ____________________ **Phone** (________) - _______ - _____________

**Name** ____________________ **Phone** (________) - _______ - _____________

* Note: This office will not contact your other health care providers or divulge information about you to anyone without your permission. Privacy laws state that two physicians with whom you are currently under care *can* discuss your case, but this office will not discuss you or your care with those whom you are not receiving care and will not release information without your (or your legal guardian's) signed authorization. Filling out this information is not considered to be authorization.

## How Did You Hear About Us? (Please check all that apply and provide the specific source)

- ◻ Referred by: ____________________
- ◻ Newspaper: ____________________
- ◻ Radio Station:____________________
- ◻ Yellow pages:____________________
- ◻ Flier (found at):____________________
- ◻ Lecture (topic/location): ____________________
- ◻ Internet (site):____________________
- ◻ Other:____________________

# Family

**Spouse** ______________________________________________

**Date of Birth** ________/________/________________ (mm/dd/yyyy)

**Employer** ______________________________________________

**Occupation** ______________________________________________

**Children** Name ____________________________ Birth date ________/________/________________

Name ____________________________ Birth date ________/________/________________

Name ____________________________ Birth date ________/________/________________

Name ____________________________ Birth date ________/________/________________

Name ____________________________ Birth date ________/________/________________

# Insurance Assignment / Financial Responsibility

I certify that I and/or my dependent(s) have insurance coverage with

___________________________________________________________________________
(insert name of insurance company on this line)

and assign directly to Dr. Waln all insurance benefits, if any, for services rendered by Dr. Waln, Prince Crossing Family Chiropractic, and/or his/its agents.

I understand that I am financially responsible for all accrued charges from above whether or not paid by insurance.

I authorize the use of my signature on all insurance submissions.

Dr. Waln may use and disclose my health care information to the above named insurance company or future alternative/additional insurance companies and their agents for the purpose of obtaining payment for services, determining insurance benefits, and/or benefits payable for all services provided by Dr. Waln, Prince Crossing Family Chiropractic, and/or his/its agents.

**Signature** ____________________________________________________________

**Date** _______/_______/_______________ (mm/dd/yyyy)

**Printed Name** ____________________________________________________________

**Relationship to Patient** ____________________________________________________________

# Appointment Policy

In order to provide you the best and most cost-effective health care and to respect your valuable time (as well as all the others who seek health care at this practice), we have the following appointment policy in place to address those others whose behavior may affect your wait-time, ability to schedule appointments conveniently, and cumulative health care costs.

While people such as you will usually call our office with reasonable notice when they think they may be late or need to reschedule an appointment, we'd like each patient to read and sign the following to allow us to apply this policy consistently when those few exceptions occur.

If you believe you may be late for your scheduled appointment, please call as soon as possible (at least 2 hours prior to your appointment) to let this office know. If you need to reschedule an appointment, please do so at least 24 hours before your scheduled appointment.

Failure to do either will result in a $25 charge for the Physician's/office time reserved for you which will be required to be paid prior to receiving any other service.

Again, while most are considerate of others' time and schedules, it is necessary in the health care profession to implement such a policy to hopefully reduce such occurrences and be able to serve patients in a timely manner.

We are usually able to reschedule appointments with proper notice and will do our best to accommodate your schedule.

I have read and understand the appointment policy.

**Signature** ________________________________________________

**Date** _______/_______/_______________ (mm/dd/yyyy)

**Printed Name** ________________________________________________

**Relationship to Patient** ________________________________________________