Team Lopez Chiropractic
15497 Stoneybrook West Pkwy
Suite 180
Winter Garden, Fl 34787

TRANSIENT PATIENT

TODAY'S DATE: _____

NAME: _____ DATE OF BIRTH: _____

ADDRESS: _____ CITY _____ STATE: _____ ZIP: _____

SS NO.: _____ HOME PHONE: _____ WORK PHONE: _____

EMPLOYER: _____ ADDRESS: _____

WHEN WERE YOU LAST ADJUSTED? _____ WHAT WAS THE DOCTORS NAME? _____

NEAREST RELATIVE NOT LIVING WITH YOU: _____ PHONE: _____

WHO IS RESPONSIBLE FOR PAYMENT? ☐ SELF ☐ SPOUSE ☐ OTHER

HAVE YOU HAD ANY FALLS OR ACCIDENTS SINCE YOUR LAST ADJUSTMENT? _____

WHAT CURRENT COMPLAINT DO YOU HAVE? _____

PATIENTS INSURANCE INFORMATION

NAME OF COMPANY: _____

ADDRESS: _____

ID & GROUP NO.: _____

PHONE NO.: _____

SPOUSE'S INSURANCE

NAME OF COMPANY: _____

ADDRESS: _____

ID & GROUP NO.: _____

PHONE NO.: _____

INSURANCE INFORMATION

I understand and agree that health and accident insurance policies are an agreement between an insurance carrier and myself. Furthermore, I understand that this chiropractic office will prepare any necessary reports and forms in assist me in making collection from the insurance company and that any amount authorized to be paid directly to this chiropractic office will be credited to my account upon receipt however, I clearly understand and agree that all services rendered to me are charged to me ant that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered me will be immediately due and payable.

Patient Signature: _____ Date: _____

Doctor Signature: _____ Date: _____

CONSENT OF PROFESSIONAL SERVICES AND RELEASE OF INFORMATION

I herby authorize and release the doctor and whom ever he/she may designate and his/her assistants to administer chiropractic care, treatment, physical examination, x-rays and studies, or any clinic services that he/she deems necessary in my case; and I further authorize him/her to disclose all or any part of my (patient's) records to any person or corporation which is or may e liable under a contract to the clinic or to the patient to a family member or employer of the patient for all or part of the clicks charge. Including, and not limited to, hospital or medical services companies, insurance companies, workers compensation carriers, welfare funds or the patient's employer.

Patient Signature: _____ Date: _____

Parent/Gaurdian Signature: _____ Date: _____