CONFIDENTIAL PATIENT INFORMATION

Last Name: ______________________ First Name: __________________ MI: ____

Address: ______________________ City: ______________ St: ____ Zip: _______

Phone: ______________ Cell: ________________ Birthday: ___________

SS#: ______________________ Sex: M or F Spouse's name: ______________

Email: ______________________________________

Job Description: ______________________________ Wk Phone: ______________

Employer: ______________________________

FINANCIAL INFORMATION

Person responsible for payment: ____

Representing Law Firm: ____

Address: ______________________ City: ______________ St: ____ Zip: _______

Phone: ______________ Cell: ________________ Work: __________________

Insurance Company: ____

(Please provide insurance card at time of service)

Responsible Party Signature: ______________________________ Date: ___________

Payment is due at time of service, unless other arrangements have been made in advance.

PATIENT CONSENT: I hereby authorize the heatlthcare providers at Cove Physical Rehab, LLC, and whomever they may designate as their assistants to administer treatment as they so deem necessary.

SIGNATURE: ______________________________________ Date: ___________

Consent for treatment of Minor

I hereby authorize Cove Physical Rehab, LLC and whomever they may designate as their assistants to administer chiropractic care as deemed necessary to my dependent minor.

Minor's Name: ____

Parent/Guardian's Name: ______________________________________

SIGNATURE: ______________________________________ Date: ___________