

ENTRANCE APPLICATION

WELCOME!... WE ARE HONORED YOU CHOSE US TO EVALUATE YOUR CONDITION.

SO WE MAY FILE YOUR INSURANCE FORMS FOR YOU, WOULD YOU PLEASE FILL OUT THE PERSONAL INFORMATION BELOW?

IF YOU NEED ASSISTANCE PLEASE INFORM THE FRONT DESK PERSON. THANK YOU!

First Name _____ Middle _____ Last _____

Gender Male Female Home Phone _____ Cell Phone _____

Address _____

City _____ State _____ ZIP _____

Social Security Number _____ - _____ - _____ E-mail Address _____

Birthdate _____ Age _____ Marital Status S M W D

Job Title _____ Work Phone _____

Spouse's Name _____ Spouse's Birthdate _____

Social Security Number _____ - _____ - _____

Person responsible for this account _____

Name of person on your health insurance card _____

Name of their employer _____ City _____

Employer Phone _____

Children—Names & Ages _____

In case of emergency, whom should we contact? _____

Phone _____

FAMILY PHYSICIAN: _____

What is your primary complaint? _____

IS THIS WORKMAN'S COMPENSATION? _____ IS THIS PERSONAL INJURY? _____

I give HealthSource permission to contact me via mail, electronic e-mail, electronic text messaging, or telephone (including pre-recorded telephone calls) for purposes of appointment reminders, health messages or current in-office specials that may be of interest to me.

I understand that I am not required to sign this agreement to receive treatment. I can choose to opt-out of this agreement at any time.

Patient Signature: _____ Phone: _____ Cell Phone w/text Date: _____

Patient Informed Consent

I, _____, the undersigned patient, consent to the treatment(s) provided by this clinic. I understand that my condition may necessitate modifications from time to time of the type of treatment(s) rendered and the portions of my body that may need to be examined. I understand and consent to clinic staff providing me with verbal descriptions, when there are changes to my exam(s) and treatment(s), consent to the clinic staff providing said treatment(s) and exam(s) and hereby consent to any similar subsequent treatment(s) or exam(s). If I do not consent, I will immediately inform clinic staff. There are times when individuals other than staff may see me receive treatment at the clinic or overhear discussions of my condition or insurance. I consent to others perceiving these interactions at the clinic. If additional privacy is required, I will inform the clinic staff.

Patient Signature _____

(Office use only)

Account Number

Date