SHUEY chiropractic

SHUEY chiropractic • 817 South Elm Place, Suite 107 Broken Arrow, OK 74012
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Confidential Patient Information

Who referred you to our office? _____

Is your visit due to an accident? _____

Name: _____ Phone: _____

Address: _____ City: _____ State: _____ Zip: _____

Date of Birth: _____ Age: _____ SSN# _____ Marital Status: _____

Employer: _____ Occupation: _____

Name of Spouse: _____ SSN# _____

Spouse Employer: _____ Spouse Occupation: _____

Name of nearest relative: _____ Phone: _____

Clinic policy requires payment arrangements be made prior to first visit.

Name of responsible party: _____ Phone: _____

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that this office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to this office will be credited to my account upon receipt. I permit this office to endorse co-issued remittances for the conveyance of credit to my account. However, I clearly understand and agree that all services rendered me are charged directly to me and that I am responsible for payment. I hereby authorize any insurance company to pay the proceeds of any benefits due me directly to Stephen Shuey, D.C. *I have been advised by the doctor or a staff member that x-rays can be hazardous to an unborn child. At this time, to the best of my knowledge, I am not pregnant. I consent to having spineographic x-ray pictures taken if necessary.*

Patient Signature: _____ Date: _____

I authorize Stephen Shuey, D.C. And his staff to administer such procedures and treatment as they deem necessary. They have implied no guarantees to cure.

Patient Signature: _____ Date: _____

Signature of Legal Representative: _____ Relationship: _____
(Attorney-In-Fact, Guardian or parent if minor)