**PATIENT ENTRANCE FORM**

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Date |  | | | | | | | |  | | | | | | | | | Circle:  Male  Female | | | | | | |
| Name |  | | | | | | | Birth Date (dd/mm/yy) | | | | | | |  | | | | | | | Age | |  |
| Address | | |  | | | | | | Apt # |  | City | | |  | | | | | | Province | | |  | |
| Postal Code | | | | |  | | Home # | | |  | | | | | | | Cell # | | | |  | | | |
| Work # | |  | | | | | | | | E-MAIL | | |  | | | | | | | | | | | |
| Occupation | | | |  | | | | | | | | | Employer | | | |  | | | | | | | |
| Name of Emergency Contact | | | | | |  | | | | | | | | | | Contact # | | |  | | | | | |
| *How were you referred to our office? (include NAME)* | | | | | | | | | | | |  | | | | | | | | | | | | |

|  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Family Dr and # | | |  | | | | | Last physical exam date | | |  |
| Surgeries or illnesses (include dates) | | | | |  | | | | | | |
| Fractures or past injuries (include dates) | | | | | | |  | | | | |
| Medications |  | | | | | | | | | | |
| X-PAYS taken: Yes No | | | | Date | |  | | | Results |  | |
| *Have you been treated for any health condition by a physician/chiropractor in the last year? Yes No* | | | | | | | | | | | |
| If yes, describe | |  | | | | | | | | | |

|  |  |
| --- | --- |
| Extended Health Care Company |  |

Do you need any help retaining information about health insurance coverage? Yes No

AUTHORIZATION AND RELEASE

I authorize the doctor to release all information necessary to communicate with personal healthcare provides.

PAYMENT POLICY

I understand that payment is due at the time professional services are rendered to me. I understand that I am responsible for all costs of treatment care, regardless of insurance coverage.

MISSED APPOINTMENT POLICY

There is a $10 fee for missed appointments without any notification. Our office does not change for cancelled appointments, but requests 12 hours notice to reschedule an appointment. This will enable us to offer your cancelled time to other patients that desire to get their treatment completed.

|  |  |  |  |
| --- | --- | --- | --- |
| Patient’s Signature |  | Date |  |

|  |  |  |  |
| --- | --- | --- | --- |
| Guardian’s Signature Authorizing Care |  | Date |  |

Patient Entrance Form