



## New Patient Information

### Personal Information

Name: \_\_\_\_\_ Date: \_\_\_\_\_  
Address: \_\_\_\_\_ Gender: Male Female  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ Intersex Transgender  
Marital Status: Married Single Divorced Separated Widow  
Home Phone# \_\_\_\_\_ Alternate Phone# \_\_\_\_\_  
Work Phone# \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
E-mail: \_\_\_\_\_  
Who to call in case of an emergency? \_\_\_\_\_

### Employment Information

Employer: \_\_\_\_\_  
Employer's Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ Occupation \_\_\_\_\_

### Referral Information

How were you referred to our clinic (Please Circle One): Intern Family/Friend Student  
Patient Staff Faculty Yellow Pages Drive-by Sport Event SPEAK Event Promotion  
Internet/Ad/Other (Please Specify Source): \_\_\_\_\_

### Payer Information

Do you have insurance? Yes No Are you covered by Medicare\*? Yes No  
Are you a full-time student? Yes No Are you a current PCCW Student? Yes No  
(\*If you are covered by Medicare, please present your Medicare Card at time of service).

### Accident/Illness

Was this an illness and/or injury caused by an accident? Yes No  
If yes, did the accident occur at work? Yes No  
Is this an illness and/or injury caused by an auto accident? Yes No  
If yes, date of accident? \_\_\_\_\_ Dates missed from work: \_\_\_\_\_  
Describe where and how the accident or cause of injury occurred, including location and time:



Have you seen other doctors for your injury/illness?      Yes      No

If yes, name of doctor(s) seen: \_\_\_\_\_

Have you ever been treated by a chiropractor? \_\_\_\_\_

If yes, please provide the name of the chiropractor: \_\_\_\_\_

**Consent for Treatment of a Minor**

I, being the lawful parent or guardian of \_\_\_\_\_,  
the minor age of \_\_\_\_\_ do hereby give consent to authorize and request Palmer College of  
Chiropractic Clinics to examine and administer such treatment deemed advisable, necessary or  
requested on the above minor.

Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Witness Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**Consent for Use of Treatment Medical Records**

I, \_\_\_\_\_, consent to receive health care services  
at Palmer College of Chiropractic Clinics. I understand and consent that my care will be directed  
and administered by one of the licensed staff doctors along with one or more of the Palmer  
College of Chiropractic Clinics interns under the doctor's supervision.

I understand that Palmer College of Chiropractic Clinics is part of Palmer College of Chiropractic,  
West Campus, an academic and educational institution. As such, medical records provide  
valuable research and educational information. Protocol to maintain patient confidentiality is  
strictly followed. I give permission to use my records for such purposes.

I consent to the involvement of interns in my care at Palmer College of Chiropractic Clinics and  
the use of my treatment information for educational as well as research purposes.

\_\_\_\_ Please check here if you do not wish to have your patient information used for research  
and education.

Please sign below for Consent of Treatment

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_



**Acceptance of Financial Responsibility**

I understand that I am financially responsible for all services received regardless of any insurance decision regarding the necessity of care or denial of payment. I have been advised and understand that payment for services not covered by a third party payor is expected in full at the time service is provided. If I am not able to pay at the time of service, I understand that I may make arrangements to schedule payment in advance. I further understand that care may be denied at any time if I fail to meet the obligations of those arrangements.

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**Palmer College of Chiropractic, West Campus Clinic**  
**Acknowledgement of Receipt – Notice of Privacy Practices**

I, \_\_\_\_\_, acknowledge that I have received, reviewed, understand, and agree to the Notice of Privacy Practices for Palmer College of Chiropractic Clinics. This acknowledgement describes the practices, policies, and procedures regarding the use and disclosure of any of my Protected Health Information created, received or maintained by Palmer College of Chiropractic Clinics.

Date: \_\_\_\_\_ Signature: \_\_\_\_\_

Printed Name: \_\_\_\_\_

**For Office Use Only; if Notice not Provided to Patient (Please make notes in space below).**

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|--|
| For Office Use Only:                             |
| Chart Number: _____ Intern: _____                |
| Clinician: _____ Financial Class Assigned: _____ |
| Information Taken By: _____ Date: _____          |