

CALVERT CITY CHIROPRACTIC

WELCOME TO OUR OFFICE

NAME _____ DATE _____
(First) (Middle) (Last)

ADDRESS _____ CITY _____ STATE _____ ZIP _____

E-MAIL ADDRESS _____

PHONE(____) _____ BIRTHDATE _____ SS# _____

EMPLOYER _____ PHONE# _____

STUDENT: FULL ___ PART ___ MARITAL STATUS: M S D W

SPOUSE/PARENT _____ BIRTHDATE _____

SS# _____ EMPLOYER & PHONE # _____

Is your condition due to an accident? ___ Date ___ Type of accident: (Circle) Auto Work Other

Insurance _____ Insured's Name _____

Secondary Insurance _____ Insured's Name _____

Attorney's Name/Address/Phone#: _____

Medical Doctor's Name/Address: _____

WHOM MAY WE THANK FOR REFERRING
YOU? _____

I hereby authorize and request that you release the complete medical records in your possession concerning my illness and/or treatment to Dr. Bradley Tack, Dr. Lisa Tack or Dr. Charles Epstein at Calvert City Chiropractic.

I hereby give permission to the doctor to release any information requested by my insurance company/attorney acquired in the course of my treatment.

I hereby authorize and direct my insurance benefits to be paid directly to the doctor. I am financially responsible for non-covered services.

I hereby give permission to the doctor to administer treatment and perform such general procedures as he may deem necessary in the diagnosis and/or treatment of my condition.

SIGNATURE _____ DATE _____

I HAVE READ AND AGREE TO THE ABOVE STATEMENTS

PHONE: (270)395-4540

FAX: (270)395-7715

CALVERT CITY CHIROPRACTIC
5131 U.S. HIGHWAY 62
CALVERT CITY, KY 42029
(800)455-1811