HS HealthSource®
Chiropractic & Progressive Rehab™

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

Employer ____________________ Work Phone ________________

Spouse's Name ____________________ Spouse's Birthdate ________________

Person responsible for this account ______________________________

DOB of Insured Party ________________

Social Security Number _____-____-_____

Name of their employer ________________ City ________________

Employer Phone ______________________________

Children–Names & Ages ______________________________

____

In case of emergency, whom should we contact? ________________

Relationship of Emergency Contact: ________________

Phone ________________

FAMILY PHYSICIAN: ______________________________

What is your primary complaint? ______________________________

____

IS THIS WORKMAN'S COMPENSATION? ______ **IS THIS PERSONAL INJURY?** ______

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**

Form ENT APP 020211