

CONFIDENTIAL PATIENT INFORMATION

Staker Chiropractic Center
3550 NW Cary Parkway, Suite 104 Cary, NC 27513
919-460-1515

Acct. # _____ Date _____

Name (first) _____ (middle) _____ (last) _____

Home Address _____ Phone (home) _____ (cell) _____

City _____ State _____ Zip _____ SS# ____/____/____ Sex ___M ___F

Age ___ Date of Birth ____/____/____ Married ___ Single ___ Other ___ Spouse's name _____

Occupation _____ Employer _____

Office Address, City, State _____ Phone (office) _____

Insured's Name _____ Insured's Date of Birth ____/____/____ Insured's SS# ____/____/____

Insured's Employer _____ Name of Insurance Company _____

Nearest relative or friend who may be called in case of emergency _____

Relationship _____ Phone _____

Previous Chiropractic Care ___ Yes ___ No Doctor's Name _____

Major Complaint _____

Who (or what source) referred you? _____

It is usual and customary to pay for services as rendered unless otherwise arranged.

I do hereby authorize Staker Chiropractic to furnish my Insurance Co. With full report of physical examination, diagnosis, treatment prognosis, etc. of myself in regard to my injury, if requested by them.

I hereby authorize and direct payment directly to said doctor such sums as may be due on owing him for chiropractic service rendered me. I understand I am directly and fully responsible to said doctor for all medical bills submitted by him for service rendered me. This agreement is made solely for said doctor's additional protection and in consideration of him awaiting payment.

I have read and agree to be bound by the terms of this assignment of benefits. I have also been advised that if my insurance company does not cooperate in protecting said doctor's interest, he will not await payment but may declare the entire balance due and payable; these assigned proceeds shall not exceed amounts due and payable to said doctor for services rendered.

I hereby authorize Dr. Todd Staker and whomever he may designate as his assistants to administer treatment, including x-rays and examination, necessary to treat at Staker Chiropractic Center.

Signature _____ Minor's Name _____ Date ____/____/____