



PATIENT INFORMATION

Name _____
Last First Initial

Birthday _____ Social Security # _____

Address _____
Street City State Zip

Email _____

Cell Phone _____ Work Phone _____ Home Phone _____

Who may we thank for referring you to us? _____

Emergency contact: _____ Phone _____

Relationship _____

Primary Insurance

Insured Name _____ Soc Sec# _____ Birthdate _____

Insurance Company _____ Subscriber ID _____

Group # _____ Phone _____

Main subscriber (self or spouse) ID# _____

Name _____ Phone _____

Soc Sec# _____ Birthdate _____

Secondary Insurance

Insured Name _____ Soc Sec# _____ Birthdate _____

Insurance Company _____ Subscriber ID _____

Group # _____ Phone _____

Main subscriber (self or spouse) ID# _____

Employer Name _____ Phone _____

Soc Sec# _____ Birthdate _____

Patient's or Guardian's Signature

Date



X-RAY CONSENT FORM

Patient Name: _____ **Date:** _____

During your examination, the doctor may feel that X-rays/pictures will be needed in order to diagnose your condition. We would like to make you aware that X-rays may be required in order to administer treatment. In order to perform x-rays /pictures on any patient our office requires the patient's consent for such tests to be performed.

Please Choose One:

_____ **I understand that my condition may require my doctor to take X-rays to diagnose my symptoms.**

_____ **I choose not to have X-rays at this time and release my doctor of all liabilities.**

Please be advised X-rays and records request will have a charge of \$50

Please allow 48 hours to process your request

Signature: _____ **Date:** _____

Females Only:

I understand that if I am pregnant and have X-rays taken which expose my lower torso to radiation, it is possible to injure the fetus. I have been advised that ten (10days) following onset of a menstrual period are generally considered to be safe for X-rays exams. With those factors in mind, I am advising my doctor that :

I am pregnant _____ **Yes** _____ **No**

I don't know if I could be pregnant _____ **Yes** _____ **No**

Signature: _____ **Date:** _____