Showers Chiropractic and Acupuncture Clinic

Confidential Patient Information

Date __________

Patient Data

First Name:______________________ Last Name:____________________________ Middle Initial:______

Called Name: __________________ Address: ______________________________City/State/Zip:________

Home Phone: (   )______________ Work Phone: (   )_______________Cell Phone: (   )______________

Email: ________________________________ Sex: Male Female Marital Status: S M D W

Birth Date____/____/____ Social Security #: __________________ Referred by: _____________________

Work Status (Circle if applicable): Employed Full-time Student Part-time Student

Employer: ___________________________________Occupation: _________________________________

Number of Children: __________Name of Primary Care Physician: __________________________________

Emergency Contact

Name: ______________________________ Relation: ___________________________________

Home Phone: (   )______________________ Work Phone: (   )_____________________________

Cell Phone: (   )______________________ Address: _____________________________________

Condition Information

Your condition is related to : (Circle if applicable) Employment Auto Accident Other Accident

Sports/Recreation Injury Other_____________________ Condition Date or Injury Date: ____________

Insured's Information

Patient's relationship with the insured: Self Child Wife Husband Other

Insured's Name:________________________ Address____

City, State, Zip:_____________________________ Phone Number: (   )____________________________

Birth Date ____/____/____ Insured's SSN: _______________________ Group #:_______________________

ID#______________________ Insursed's Employer______________________

Insured's Date of Birth___/___/___ Employer_______________

Authorization and Assignment

In Consideration of your undertaking to care for me, I agree to the following:

1. You are authorized to release any information you deem appropriate concerning my physical or emotional condition and/or health history to any insurance company, attorney, or adjuster to process any claim for reimbursement of charges incurred.
2. I authorize my attorney and/or any insurance company to make **direct payment to you** of settlement proceeds.
3. I hereby assign and transfer to you the cause of action that exists in my favor against any insurance company obligated by contractual agreement to make payment to me or to you for the charges made for your service. I authorize you to prosecute said action either in my name. I further authorize you to compromise, settle, or otherwise resolve said claim as you see fit. I understand that whatever amounts you do not collect from insurances companies, whether it be all or part of what was due, **I personally owe you**.
4. In addition, I hereby waive the statute of limitations on collection and/or recovery in this state of Missouri
5. I further agree that this Authorization and Assignment is irrevocable until all moneys owed Showers Chiropractic and Acupuncture Clinic, LLC are paid in full.

Signature________________________________Date: ______________________