DiSalvatore Chiropractic
1956 West Prospect Road Ashtabula, Ohio 44004
(440) 992-0160 (440) 998-0121(Fax)

CONFIDENTIAL PATIENT INFORMATION

Date: _____

Please circle your preferred method of contact:

Patients Name: _____ **Home Phone:** _____

Address: _____ **Cell Phone:**_____

City: _____**State:** _____**Zip:**_____ **Email:** _____

SS#:_____ **Marital Status:** S M D W

Ethnicity: Not Hispanic or Latino Hispanic or Latino **Date of Birth:** _____

Please Circle:
Race: White Black or African-American Asian Native Hawaiian American Indian or Alaskan Native Other Race
Preferred Language: English Spanish French German Italian Russian Portuguese Chinese Japanese Korean
Smoking Status: Current Every Day Smoker Current Some Day Smoker Former Smoker Never a Smoker (less than 100) Smoker, Current Status Unknown Unknown if Ever Smoked

Occupation: _____ **Number of Children:** _____

Employer: _____ **Address**: _____

Person to contact in case of emergency (Name and Phone):_____

Have you ever been under Chiropractic Care? ____ Yes ___ No If so, Who? _____

How did you hear about our office? _____

INSURANCE:
Insurance Company: _____**Insured Name (if different from patient):** _____
Relationship to Patient: _____**Insured Date of Birth:** _____
SS#: _____ **Employer:** _____

Is your condition due to an auto accident or job related injury? _____ Yes _____No

OUR OFFICE POLICY REGARDING INSURANCE ASSIGNMENT

I understand and agree that health and accident polices are an arrangement between an insurance carrier and myself. Furthermore, I understand that the office of Thomas D. DiSalvatore, D.C. Inc. will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to Thomas D. DiSalvatore, D.C. Inc. will be credited to my account upon receipt. However, I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered me will be immediately due and payable. I authorize the office of Thomas D. DiSalvatore, D.C., Inc. to release any medical information necessary to process my insurance claims. I further authorize payment by my insurance company to Thomas D. DiSalvatore, D.C. Inc. for services rendered by the doctors of Thomas D. DiSalvatore, D.C. Inc. if I have not paid for the services. Any overpayment by the insurance company will be returned to the patient or the insurance company. This authorization will continue in effect until I give written authorization not to release such information. I authorize payment of medical benefits to Thomas D. DiSalvatore, D.C. Inc. for services provided.

I will be paying today by _____ Cash _____ Check _____ Credit Card

_____MasterCard _____ Visa _____ Discover Card # _____ Exp. Date _____

All accounts not paid within 60 days will automatically be put through on your credit card.

Signature: _____ Date: _____