

Wellness Chiropractic Center
543 Third Street Suite A-3
Lake Oswego, OR 97034
(503) 636-6186

Welcome! In order to help me keep complete records and submit accurate bills to your insurance company, please assist me by providing the following information.

YOUR INFORMATION:

Date: _____ Name: _____
Address: _____ City: _____
State: _____ Zip: _____ Home Phone: _____ Cell: _____
Sex: F M Marital Status S M D W Age: _____ Birthdate: _____
Name of Spouse, Parent or Guardian: _____
Nearest relative: _____ Phone: _____
Names and ages of children: _____
Who referred you to this office? _____

WORK/SCHOOL INFORMATION:

Occupation: _____
Employer: _____ Address: _____
City: _____ State: _____ Zip: _____ Work Phone: _____
Status: Full Time Part Time Retired

If you are a student what school are you attending? _____
Full Time Part Time Major: _____ City: _____ State: _____

PERSON RESPONSIBLE FOR PAYMENT

Name: _____
Address: _____ City: _____
State: _____ Zip: _____ Phone: _____ Sex: F M Birthdate _____

AUTHORIZATION TO TREAT AND RELEASE RECORDS:

By my signature I authorize Dr Joan Schultze to provide chiropractic care and/or BodyTalk sessions to me. Signature: _____

I hereby authorize the release of any medical information necessary to process claims. I also authorize payment of medical benefits to Dr Schultze for services rendered. Should the amount be insufficient to cover the entire expense, I will be responsible to her for the balance due.

Signature: _____ Date: _____