BOSSIER CHIROPRACTIC CENTER

ABOUT YOU: (please print) Today's date_____

Name:_____ ☐ Male ☐ Female

Date of birth:_____ Age:_____ SS#:_____

Home Address_____

_____

City State Zip

Home Phone #:_____ Cell #:_____Other Phone_____

Employer:_____How Long:_____

Occupation:_____

Address:_____

City State Zip

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

Referred by: ☐ Phone Book ☐ Friend or Relative ☐ Other

ABOUT YOUR SPOUSE:

Their Name:_____Date of birth _____

Home Phone:_____ Work Phone:_____

Employer:_____ SS#:_____

IN THE EVENT OF AN EMERGENCY, WHO SHOULD WE CONTACT?

Name_____ Relation?_____

Home Phone:_____ Work Phone:_____

DESIRED METHOD OF PAYMENT: ☐ Cash ☐ Check ☐ Credit Card

IS CONDITION DUE TO ACCIDENT OR INJURY? ☐ Yes ☐ No ☐ Auto ☐ Work ☐ Other

PRIMARY CARE PHYSICIAN:_____ (**over**)

We invite you to discuss frankly with us any questions regarding our services. The best medical service is based on a friendly, mutual understanding between physician and patient.

Our office policy requires payment in full for all medical services rendered at the time of visit, unless other arrangements have been made with the Office Manager. If the account is not paid within 30 days of the date of service, and no financial arrangement has been made, you will be responsible for any expenses incurred in collecting your account.

I, the undersigned, a patient in this clinic, hereby authorize Dr. James A. Wiseman (and whomever may be designated as assistants) to administer such treatments as are necessary. Also, authorization is hereby granted to release to the responsible Insurance Company, my attorney, or my employer any information deemed necessary for the filing and/or the completion of my insurance or other claims. If insurance is used for credit, I will assume full responsibility for all charges not covered by my insurance company. For credit to continue, payment must be made when billed or requested.

I hereby authorize payment of medical benefits directly to physician of benefits due me for services rendered. I also authorize Dr. James A. Wiseman to obtain legal counsel to initiate legal proceedings against my insurance company, in the event of failure to honor this assignment of benefits or failure to pay, those proceedings to include penalties, attorney's fees and court costs.

AUTHORIZATION TO RELEASE MEDICAL INFORMATION: I hereby authorize and direct any physician, hospital, medical attendant, nurse, technician, or others, to furnish to Dr. James A. Wiseman records and/or x-rays pertinent to my condition. A copy of this authorization shall have the same force and effect as the original.

Date _____ Signed X _____

Witness _____ or _____

(parent or legal guardian, if minor)

I ALSO AUTHORIZE DR. WISEMAN TO RELEASE INFORMATION ABOUT MY CONDITION TO ANY OF MY OTHER PHYSICIAN'S AS HE DEEMS NECESSARY.