# Patient History

(please print legibly)

Name_____ SS#_____-_____-_____ Date____/____/____

Address_____ City_____ State____ Zip_____

Phone (____)_____-_____ Cell (____)_____-_____ Email_____

Status (circle) Married Divorced Single **Sex** Male Female **DOB**___/___/___ **Age**____

Individual Responsible for Account (if different from patient)_____

Primary Care Physician_____ Referred by_____

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Employer_____ Phone (____)_____-_____

Address_____ City_____ State____ Zip_____

Describe your Job Duties_____

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## If you are not the PRIMARY CARD HOLDER, we need the following information

Insured Name_____ SS#_____-_____-_____ DOB____/___/____

Address_____ City_____ State____ Zip_____

Employer_____ Relation_____

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Since my last visit I have been seen by Dr._____ For_____

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### Assignment of Benefits, Authorization for Release of Information, and Consent

1) **Assignment of Benefits:** I hereby direct my Insurance Carrier(s) or Attorney to pay by check made and mailed directly to: **Garlett Chiropractic Clinic, PC, 4141 NW Expressway, Suite 385, Oklahoma City, OK 73116.**

2) I also understand that I am personally responsible and agree to pay, in a current manner, any balance due after payment or non-payment by my Insurance Carrier(s) or Attorney.

3) **Authorization for Release of Information:** I hereby authorize the release of any pertinent information to any Doctor, insurance company, adjuster, or attorney involved in this claim.

4) A photocopy of this document shall be considered as effective and valid as the original.

5) **Consent:** I give permission to the doctor and his staff to administer treatment and perform such procedures as deemed necessary in the diagnosis and treatment of named patient.

**Patient/Guardian Signature**_____

I have read and agree to the above statements

Garlett Chiropractic Clinic, PC, 4141 NW Expressway, Suite 385, Oklahoma City, OK 73116