Robert Schellenberg D.C., P.A.

Patient Intake Form

Patient Information

Full Name: ______________________________ Date: __________
First MI Last

Permanent Address: ______________________________
Street City State Zip

Seasonal Address: ______________________________
Street City State Zip

Home phone: (   ) __________ Cell Phone: (   ) __________ Cell Phone Carrier: (   ) __________

Age: ______ Birth Date: __________ Female: ___ Male: ___ Social Security Number: __________

Email Address: __________ Marital Status: ______ # of Children: ______ Age(s): ______

How did you hear of us? __________ Who referred you to us? __________

Work Phone: (   ) __________ I prefer to receive calls at: (circle one) Home/Work/Cell

Employer: __________ Occupation: __________

Employer's Address: __________ City: __________ State: ______ Zip: ______

Spouse's Name: __________ Spouse's Cell Phone: __________

Emergency Contact other than spouse: __________ Emergency Contact Phone: __________

Payment Information

Person Responsible for Payment: __________ Relation to Patient: __________

Social Security Number: __________ Date of Birth: __________ Phone: __________

Insurance Information

Do you have health insurance? _____ Yes _____ No Name of my insurance carrier(s) : __________

Please have your insurance card and driver's license ready so they can be copied for our records.

Consent for Treatment

Assignment & Release *- By signing below, I authorize Robert Schellenberg, DC, PA to release medical records required by my insurance company(s). I authorize my insurance company(s) to pay benefits directly to Robert Schellenberg, DC, PA and I agree that a reproduced copy of this authorization will be as valid as the original. I understand that I am responsible for any amount not covered by my insurance, or any amount for a patient for which I am the guarantor. I agree that I will be responsible for any collection agency or attorney fees incurred. I understand that by signing below, I am giving written consent for the use and disclosure of protected health information for treatment, payment, and health care operations.*

By signing below, I give my consent for examination and the performance of any tests or procedures needed. If patient is a minor, by signing I give consent for examination, tests and procedures for the above minor patient.

Signed __________ Printed Name __________

Date __________ Relation to patient if patient is a minor __________