Welcome!!!

Dr. Dolak and his staff welcome you and want to provide you with the best possible care. We will conduct a history and examination to decide if we can assist you. If we do not believe that your condition will respond to chiropractic care, we will not accept you as a patient, but will refer you to another health care provider, if appropriate.

Patient Information

Name: _____ Date of Birth: ___/___/___ Age: _____

Address: _____ Sex: M F

City: _____ Marital Status: S M D W

State: _____ Zip: _____ Social Security No: _____

Home Phone: _____ Student: FT PT

Cell Phone: _____ Email Address: _____

Referred by: _____ Chief Complaint: _____

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Employer: _____ Occupation: _____

Location: _____ Work Phone: _____

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Family Information

Spouse's Name: _____ Date of Birth: _____/_____/_____

Child's Name: _____ Date of Birth: _____/_____/_____

Child's Name: _____ Date of Birth: _____/_____/_____

Child's Name: _____ Date of Birth: _____/_____/_____

Child's Name: _____ Date of Birth: _____/_____/_____

Child's Name: _____ Date of Birth: _____/_____/_____

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I understand and agree that all services rendered to me are my financial responsibility. I further understand and agree that health, accident, or other insurance policies are and arrangement between the insurance carrier and myself. I am aware that as a courtesy, Dr. Dolak will assist me in preparing the appropriate forms. I further agree that all insurance benefits will be assigned directly to Dr. Dolak and will be credited to my account upon receipt. Any amounts not paid by my insurance company will be billed to me and paid within (60) days. I hereby authorize and give specific Power of Attorney to Dr. Dolak to endorse my name to any and all checks, drafts or money orders which are made payable to the undersigned and/or to Dr. Dolak, which are paid by my insurance company for services rendered me.

I authorize the release of any information concerning my health and health care services to my insurance companies, prepaid health plan or Medicare.

_____ _____

Date **Patient's or Guardian's Signature**