THE BACK ALLEY
CHIROPRACTIC & MASSAGE

PATIENT UPDATE

Please take the time to complete these forms to the best of your ability. If you have any questions, we will be glad to assist you.

Patient Full Name _____ Date of Birth _____

Mailing Address _____

City _____ State _____ Zip Code _____

Email Address _____ Cell Phone _____

By providing an email address, you are giving explicit consent and agree to receive communication and marketing emails (see our HIPAA notice for more details)

Home Phone _____ Work Phone _____

Emergency Contact Name & Phone # _____

COVERAGE INFORMATION

If you are **Self Pay**, please request a copy of our updated fee schedule. If you are **Insured**, please provide your insurance card(s) to reception. Digital cards should be emailed to thebackalleychiro@yahoo.com.

☐ Self Pay ☐ Health Insurance ☐ Medicare/Medicaid

SYMPTOMS

Describe your ***current*** symptoms and ***how*** they began:

_____

_____

_____

How extreme are your ***current*** symptoms? (circle one)

0 1 2 3 4 5 6 7 8 9 10

Absent Uncomfortable Agonizing

I authorize the release of any medical or other information necessary to process my claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

I authorize payment of medical benefits to The Back Alley Chiropractic and its physicians or supplier for services received.

To the best of my ability, the information I have supplied is complete and truthful. At any time, I may request a copy of the Privacy Policy and understand it describes how my personal health information is protected and may be released. I grant permission to be called or emailed to confirm or reschedule an appointment and to be sent occasional cards, letters or emails as an extension of my care in this office.

Print Patient Name _____

Patient or Parent/Guardian Signature _____ Date _____