

DiSalvatore Chiropractic

Thomas D. DiSalvatore, D.C.
1956 West Prospect Road
Ashtabula, Ohio 44004

Adam M. Davis, D.C., Dipl. Ac.
Office (440) 992-0160
Fax (440) 998-0121

CONFIDENTIAL CASE HISTORY

PATIENT INFORMATION:

Date: _____ Social Security Number: _____ - _____ - _____

Name: _____

Address: _____
Last First MI
Number & Street P.O. Box City State Zip

Telephone: (Home): () _____ (Cell): () _____ (Work): () _____

Email Address: _____

Gender : M F Marital Status: S M D W Number of Children: _____

Date of birth: ____ / ____ / ____ Age: _____ Occupation: _____

Employer: _____ Address: _____

NEAREST FRIEND OR RELATIVE WHO MAY BE CONTACTED IN AN EMERGENCY:

Name: _____ Phone: () _____

Have you ever been treated by a Chiropractor before? _____ Yes _____ No If yes, When? _____

How did you hear about our office? _____

INSURANCE:

Insurance Company: _____

Insured Name (if different from patient): _____ Relationship to Patient: _____

Insured Date of Birth: _____ SS#: _____ - _____ - _____ Employer: _____

Is your condition due to an auto accident or job related injury?: _____ Yes _____ No

OUR OFFICE POLICY REGARDING INSURANCE ASSIGNMENT

I understand and agree that health and accident policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that the office of Thomas D. DiSalvatore, D.C., Inc. will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to Thomas D. DiSalvatore, D.C., Inc. will be credited to my account upon receipt. However, I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered me will be immediately due and payable.

I authorize Dr. Thomas D. DiSalvatore and/or Dr. Adam M. Davis to release any medical information necessary to process my insurance claims. I further authorize payment by my insurance company to Thomas D. DiSalvatore, D.C., Inc. for services rendered by Dr. DiSalvatore and/or Dr. Davis if I have not paid for the services. Any overpayment by the insurance company will be returned to the patient or the insurance company. This authorization will continue in effect until I give written authorization not to release such information. I authorize payment of medical benefits to Thomas D. DiSalvatore, D.C., Inc. for services provided.

I will be paying today by _____ Cash _____ Check _____ Credit Card
_____ MasterCard _____ Visa _____ Discover Card # _____ Exp. Date _____

All accounts not paid within 60 days will automatically be put through on your credit card.

Signature: _____ Date: _____