# Powers Chiropractic PC

## Confidential Patient Information

The following information is needed in order to better serve you. Please complete all questions. If you need help, please ask the receptionist. PLEASE PRINT

Name_____ Today's Date_____
Home Phone_____
Address_____ City_____ State____ Zip_____
Age_____ Birthdate_____

Your Employer_____
Occupation_____Office Phone _____

Is your condition due to an accident? Yes__ No __Date of Accident_____

Type of accident? Auto___ Work/On Job ___ At Home ___
Other_____

Have you ever been in an Auto Accident? Past Year __Past 5 years ___ Over 5 years ___
Never _____

I understand that Powers Chiropractic is an all cash practice and I (we) agree to pay for services rendered to the above mentioned patient at the end of each days treatment. I also understand that Powers Chiropractic does not accept insurance. If I suspend **or** terminate my care and treatment, any fees for professional services rendered to me will be immediately due and payable.

Patient's Signature _____ date_____

Spouse or Guardian's Signature _____ date _____